State: *Tennessee* ***Filing Company:*** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

Filing at a Glance

Company:	Humana Insurance Company
Product Name:	Individual Dental Insurance
State:	Tennessee
TOI:	H10I Individual Health - Dental
Sub-TOI:	H10I.000 Health - Dental
Filing Type:	Form/Rate
Date Submitted:	06/04/2013
SERFF Tr Num:	HUMA-128968624
SERFF Status:	Closed-Approved
State Tr Num:	H-130807
State Status:	Approved
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Laura Kocken, Nancy Anderson, Steve Laabs, Tina Huettl, Benjamin Ligocki, Josh Fink
Reviewer(s):	Vicky Stotzer (primary), Melissa Merritt, Brian Hoffmeister, Art Lucker
Disposition Date:	07/30/2013
Disposition Status:	Approved
Implementation Date:	

State Filing Description:
I DEN P
TN HUMD IND 2014
individual dental on and off exchange policy

State: *Tennessee* ***Filing Company:*** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

General Information

Project Name: Stand-alone Dental
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Nancy Anderson

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This policy is being submitted in our domicile state simultaneously with this filing.

Market Type: Individual
Individual Market Type:
Filing Status Changed: 07/30/2013
State Status Changed: 07/30/2013
Created By: Nancy Anderson
Corresponding Filing Tracking Number:

Filing Description:

The forms included in this filing are intended for use with new individual dental plans on and off exchange.
These form(s) support the current 2014 ACA Federal requirements and business initiatives. To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Tennessee statutes and regulations.

Company and Contact

Filing Contact Information

Nancy Anderson, Regional Contract Analyst nanderson1@humana.com
500 W. Main Street 502-580-4230 [Phone]
NCT-1
Louisville, KY 40202

Filing Company Information

Humana Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
(800) 558-4444 ext. [Phone]

CoCode: 73288
Group Code: 119
Group Name:
FEIN Number: 39-1263473

State of Domicile: Wisconsin
Company Type: Life & Health
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Vicky Stotzer	07/30/2013	07/30/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Company Response	Vicky Stotzer	07/26/2013	07/26/2013
Pending Company Response	Art Lucker	07/25/2013	07/25/2013
Pending Company Response	Art Lucker	07/12/2013	07/12/2013
Pending Company Response	Melissa Merritt	07/05/2013	07/05/2013

Response Letters

Responded By	Created On	Date Submitted
Nancy Anderson	07/30/2013	07/30/2013
Benjamin Ligocki	07/26/2013	07/26/2013
Benjamin Ligocki	07/23/2013	07/23/2013
Nancy Anderson	07/10/2013	07/10/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Extension until July 24, 2013	Note To Filer	Art Lucker	07/22/2013	07/22/2013
Request for Extension	Note To Reviewer	Benjamin Ligocki	07/19/2013	07/19/2013
Rating Areas	Note To Filer	Brian Hoffmeister	06/07/2013	06/07/2013

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Disposition

Disposition Date: 07/30/2013
Implementation Date:
Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter Accident & Health	Approved	Yes
Supporting Document	Description of Variables	Approved	Yes
Supporting Document	Filing Fees	Approved	Yes
Supporting Document	Readability Certification	Approved	Yes
Supporting Document	Third Party Authorization	Approved	Yes
Supporting Document (revised)	Actuarial Memorandum A & H Certification - Individual	Approved	Yes
Supporting Document	Actuarial Memorandum A & H Certification - Individual	Replaced	Yes
Supporting Document	Accident & Health - Individual New Rates	Approved	Yes
Supporting Document	Response letter	Approved	Yes
Supporting Document	Claims Trend Graph	Approved	Yes
Supporting Document	Tennessee Rating Areas	Approved	Yes
Supporting Document	Response letter 7.30.13	Approved	Yes
Form (revised)	Policy Cover	Approved	Yes

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Policy Cover	Replaced	Yes
Form	Table of Contents	Approved	Yes
Form	Preferred Provider Organization	Approved	Yes
Form	Adult Dental Benefit	Approved	Yes
Form (revised)	Pediatric Dental Benefit	Approved	Yes
Form	Pediatric Dental Benefit	Replaced	Yes
Form	Limitations & Exclusions	Approved	Yes
Form	Eligibility	Approved	Yes
Form	Changes to Your Coverage	Approved	Yes
Form	Premium Payment	Approved	Yes
Form	Termination	Approved	Yes
Form	General Provisions	Approved	Yes
Form	Definitions	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Policy Face Page	Approved	Yes
Form	Eligibility	Approved	Yes
Rate (revised)	Rate Manual	Approved	Yes
Rate	Rate Manual	Replaced	Yes

INS CONSULTANTS, INC.

Insurance Regulatory Consultants

419 S. 2nd Street
New Market, Suite 206
Philadelphia, PA 19147
Phone: (215) 625-9877
Fax: (215) 627-7104

TO: Vicky Stotzer
Health Analyst
Policy Analysis Section, Insurance Division
Tennessee Department of Commerce and Insurance

FROM: James Kuklinski, ASA, MAAA
INS Consultants, Inc.

DATE: July 26, 2013

SUBJECT: Humana Insurance Company
Individual Health – Dental
Forms: TN HUMD IND 2014 et al., TN HUMD-IND-OC-2014
SERFF Tracking Number: HUMA-128968624
Tennessee Tracking Number: H-130807

INS Consultants, Inc. (INS) has reviewed Humana Insurance Company's (Humana) individual dental filing for plans On and Off the Tennessee Exchange. Please note that for plans which are marketed both On and Off the exchange, the rates are the same.

The filing was submitted on June 4, 2013 requesting approval of new Individual Dental Policy and Outline of Coverage forms and rates, to meet both the Tennessee regulatory requirements and the Federal Affordable Care Act (ACA) requirements for offering pediatric dental Essential Health Benefits (EHB) using a stand-alone dental plan in the individual market. The filing covers one Low plan with both adult and pediatric rates, to be used both On and Off the exchange, incorporating the required pediatric dental EHB. Forms and rates are requested to become effective for new business on and after January 1, 2014.

In support of their request, Humana has provided the proposed new forms and rates, an actuarial memorandum, Rate Data Template, Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification form, and Stand-Alone Dental Plans-Description of EHB Allocation form. The actuarial memorandum includes, inter alia, plan descriptions, pricing assumptions and methodology, anticipated loss ratio (56.2%), and appropriate actuarial certifications.

After a review of the actuarial memorandum and related supporting materials, INS identified, on July 12 and 25, several matters that required additional clarification or correction. Subsequently, on July 23 and 26, Humana provided clarification and corrections that responded to the questions raised by INS.

INS has reviewed the submission in its entirety. INS has checked for compliance with Tennessee loss ratio requirements as well as for compliance with ACA requirements with respect to Actuarial Value. The anticipated loss ratio exceeds the Tennessee standard of 55% for guaranteed renewable business of this kind, and the Actuarial Value is certified to fall within +/-2% of the 70% standard for Low plans under ACA. INS's analysis also included (but was not limited to) a review of the rate manual, trend assumption, retention, administrative expense breakdown, and rate data template. Based on INS's review the rates are acceptable, the retention and administrative expenses are reasonable, the actuarial values appear to be calculated using a methodology that is reasonable, and the rates appear to be consistent across rating parameters and by plan differences.

Based on INS's review and on the certifying statements of Humana's opining actuary, INS suggests that the subject filing is compliant with Tennessee and ACA regulatory requirements. Based on this conclusion, INS suggests that the submitted rate schedules are actuarially justified.

If you have any questions or would like additional information, please do not hesitate to call or e-mail.

_____

James Kuklinski, ASA, MAAA

State: *Tennessee* **Filing Company:** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/26/2013
Submitted Date	07/26/2013
Respond By Date	

Dear Nancy Anderson,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

Comments: Please excuse my error in the non-medically necessary coverage. However, after reading further the states have the authority to approve these definitions.

Orthodontic treatment, subject to clinical review and when as a result of congenital or developmental malformations. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care.

You may not have a lifetime limit. This definition is one that could be approved.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Vicky Stotzer

State: Tennessee **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Individual Dental Insurance
Project Name/Number: Stand-alone Dental/

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/25/2013
Submitted Date	07/25/2013
Respond By Date	07/26/2013

Dear Nancy Anderson,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please address the following:

1. The Rate Manual, SERFF file TN Smart Choice Rate Manual.xlsm, contains rates for six Rating Areas. The Rate Data Template contains the rates for eight Rating Areas, though some Rating Areas receive the same rates. The Template rates all match rates in the Manual, but the Rating Areas dont line up. The correspondence appears to be Template 1/2/3/4/5/6/7/8 = Manual 2/1/3/2/5/4/6/4 or, in reverse, Manual 1/2/3/4/5/6 = Template 2/1+4/3/6+8/5/7. Please identify the Rating Areas and make the Manual and Template consistent.

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

State: *Tennessee* **Filing Company:** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/12/2013
Submitted Date	07/12/2013
Respond By Date	07/24/2013

Dear Nancy Anderson,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please address the following:

1. Please provide a discussion of compliance with the ACA and TN regulations regarding rates and benefits. Please cite the appropriate regulations. Among other problems, certain pediatric copayments and deductibles do not appear to be compliant. Also, there do not appear to be the required High and Low plans with the required Actuarial Values (AV); there is no mention of AV at all. Such information should be included in the actuarial memorandum, as well as most of the material requested below.

2. Please provide a breakdown of the retention, including administration, commissions, commission bonus, premium and other taxes, exchange fees, contingencies and risk, and profit; please provide the anticipated loss ratio.

3. Please provide the trend assumption and support.

4. Please provide the Rate Manual; please provide support for any base costs used, and for any rate distinctions as between areas or ages

5. Please provide a discussion of the model used (including methodology) to produce the AVs for high and low plans.

Conclusion:

PLEASE NOTE: The reviewer on this filing is Victoria Stotzer, if you have any questions please call her at at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons.

Sincerely,

Art Lucker

State: Tennessee **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Individual Dental Insurance
Project Name/Number: Stand-alone Dental/

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/05/2013
Submitted Date	07/05/2013
Respond By Date	

Dear Nancy Anderson,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Policy Cover, TN HUMD IND 2014 (Form)

Comments: If the important notice is variable due to the on/off exchange language, please separate and have one for off and one for the on exchange.

Objection 2

- Pediatric Dental Benefit, HUMD IND PED BEN 2014 (Form)

Comments: Orthodontic treatment, subject to clinical review and when as a result of congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care. Limited to one per lifetime.

This is not what is in the FEDVIP benefit. Please see the proper benefit, after 2 years you must cover this for non-medically necessary.

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Melissa Merritt

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**	

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/30/2013
Submitted Date	07/30/2013

Dear Vicky Stotzer,

Introduction:

Thank you for your review of our filing, and for the email you sent discussing the orthodontic treatment benefit.

Response 1

Comments:

We have changed our orthodontic benefit to remove the requirement for certain conditions and also have removed the lifetime limit.

Related Objection 1

Comments: Please excuse my error in the non-medically necessary coverage. However, after reading further the states have the authority to approve these definitions.

Orthodontic treatment, subject to clinical review and when as a result of congenital or developmental malformations. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care.

You may not have a lifetime limit. This definition is one that could be approved.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response letter
Comments:	
Attachment(s):	Response letter 7.10.13.pdf

Satisfied - Item:	Response letter 7.30.13
Comments:	
Attachment(s):	Response letter.pdf

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response letter
Comments:	
Attachment(s):	Response letter 7.10.13.pdf

Satisfied - Item:	Response letter 7.30.13
Comments:	
Attachment(s):	Response letter.pdf

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Pediatric Dental Benefit	TN HUMD IND PED BEN 2014	POL	Initial		48.700	F-GN Pediatric Dental Benefit .pdf	Date Submitted: 07/30/2013 By: Nancy Anderson
Previous Version								
1	*Pediatric Dental Benefit*	*HUMD IND PED BEN 2014*	*POL*	*Initial*		*48.700*	*HUMD IND PED BEN 2014.pdf*	*Date Submitted: 06/04/2013 By: Nancy Anderson*
2	Policy Face Page	TN HUMD IND 2014	POL	Initial		48.700	TN HUMD IND 2014.pdf	Date Submitted: 07/30/2013 By: Nancy Anderson
3	Eligibility	TN HUMD IND ELIG 2014	POL	Initial		48.700	TN HUMD IND ELIG 2014.pdf	Date Submitted: 07/30/2013 By: Nancy Anderson

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

No Rate/Rule Schedule items changed.

Conclusion:

We appreciate your time and attention to this filing. If you have any questions or need additional information please feel free to contact me.

Sincerely,

Nancy E. Anderson
Humana
500 W. Main Street
Louisville, KY 40202
(502) 580-4230
nanderson1@humana.com

Sincerely,
Nancy Anderson

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**	

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/26/2013
Submitted Date	07/26/2013

Dear Vicky Stotzer,

Introduction:

Please see the response below.

Response 1

Comments:

Response: The Humana defined rating areas for this plan adhere to the Tennessee defined rating areas. The claim levels in some of the Tennessee rating areas were similar and, as a result, were combined in our rate manual. Please see the exhibit titled Tennessee Rating Areas for a crosswalk between the rating areas. Please note that the Rate Manual has also been updated to show both definitions of rating areas.

Related Objection 1

Applies To:

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please address the following:

1. The Rate Manual, SERFF file TN Smart Choice Rate Manual.xlsm, contains rates for six Rating Areas. The Rate Data Template contains the rates for eight Rating Areas, though some Rating Areas receive the same rates. The Template rates all match rates in the Manual, but the Rating Areas dont line up. The correspondence appears to be Template 1/2/3/4/5/6/7/8 = Manual 2/1/3/2/5/4/6/4 or, in reverse, Manual 1/2/3/4/5/6 = Template 2/1+4/3/6+8/5/7. Please identify the Rating Areas and make the Manual and Template consistent.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Tennessee Rating Areas
Comments:	Please see the attached file which defines the rating areas for both Tennessee and Humana by county.
Attachment(s):	Tennessee Rating Areas.xlsx

No Form Schedule items changed.

SERFF Tracking #: *HUMA-128968624* **State Tracking #:** *H-130807* **Company Tracking #:**

State: *Tennessee* **Filing Company:** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate Manual	TN HUMD IND 2014	New		TN Smart Choice Rate Manual.xlsm,	07/26/2013 By: Benjamin Ligocki
Previous Version						
1	*Rate Manual*	*TN HUMD IND 2014*	*New*		*TN Smart Choice Rate Manual.xlsm,*	*07/23/2013 By: Benjamin Ligocki*

Conclusion:

Thank you for your review.

Sincerely,

Benjamin Ligocki

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/23/2013
Submitted Date	07/23/2013

Dear Vicky Stotzer,

Introduction:

Please see the responses below.

Response 1

Comments:

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**	

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

1. Please provide a discussion of compliance with the ACA and TN regulations regarding rates and benefits. Please cite the appropriate regulations. Among other problems, certain pediatric copayments and deductibles do not appear to be compliant. Also, there do not appear to be the required High and Low plans with the required Actuarial Values (AV); there is no mention of AV at all. Such information should be included in the actuarial memorandum, as well as most of the material requested below.

Response: Please see Item 2 in the updated Actuarial Memorandum. Please see the forms to review compliance with specific ACA and Tennessee benefit regulations. The Actuarial Memorandum is only intended to provide an overview of benefits outlined in the policy forms.

2. Please provide a breakdown of the retention, including administration, commissions, commission bonus, premium and other taxes, exchange fees, contingencies and risk, and profit; please provide the anticipated loss ratio.

Response: Please see Item 8 of the Actuarial Memorandum which now includes a breakdown of the retention components.

3. Please provide the trend assumption and support.

Response: The claims trend assumption for this plan is 6% on a prospective annual basis. Claim trend on a similar individual product has recently averaged between 5-10%. Please see the exhibit titled Claims Trend Graph.

4. Please provide the Rate Manual; please provide support for any base costs used, and for any rate distinctions as between areas or ages

Response: Please see the rate manual included in the rate/rule tab. The rate manual is also included on the supporting documentation tab labeled under Accident & Health Individual New Rates. Items 5, 12, and 13 have been updated in the Actuarial Memorandum.

5. Please provide a discussion of the model used (including methodology) to produce the AVs for high and low plans.

Response: Actuarial value is defined as paid claims divided by allowed claims. The Actuarial Value model estimates paid claims for the benefit structures as well as total allowed claims outlined in the policy forms. Humana Dental Smart Choice is a low actuarial value plan that falls within the de minimis range of 68-72%. The actuarial value analysis was conducted under review of a member of the American Academy of Actuaries and performed in accordance with generally accepted actuarial principles and methodologies.

Related Objection 1

Applies To:

- *Actuarial Memorandum A & H Certification - Individual (Supporting Document)*

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Comments: Please address the following:

1. Please provide a discussion of compliance with the ACA and TN regulations regarding rates and benefits. Please cite the appropriate regulations. Among other problems, certain pediatric copayments and deductibles do not appear to be compliant. Also, there do not appear to be the required High and Low plans with the required Actuarial Values (AV); there is no mention of AV at all. Such information should be included in the actuarial memorandum, as well as most of the material requested below.

2. Please provide a breakdown of the retention, including administration, commissions, commission bonus, premium and other taxes, exchange fees, contingencies and risk, and profit; please provide the anticipated loss ratio.

3. Please provide the trend assumption and support.

4. Please provide the Rate Manual; please provide support for any base costs used, and for any rate distinctions as between areas or ages

5. Please provide a discussion of the model used (including methodology) to produce the AVs for high and low plans.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	Please see the attached Actuarial Memorandum as well as the required A&H Certification.
Attachment(s):	TN Actuarial Certification.pdf TN Smart Choice Actuarial Memorandum.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum A & H Certification - Individual*
Comments:	*Please see the attached Actuarial Memorandum as well as the required A&H Certification.*
Attachment(s):	*TN Smart Choice Actuarial Memorandum.pdf* *TN Actuarial Certification.pdf*

Satisfied - Item:	Claims Trend Graph
Comments:	Please see the attached exhibit.
Attachment(s):	Claims Trend Graph.pdf

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	Please see the attached Actuarial Memorandum as well as the required A&H Certification.
Attachment(s):	TN Actuarial Certification.pdf TN Smart Choice Actuarial Memorandum.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum A & H Certification - Individual*
Comments:	*Please see the attached Actuarial Memorandum as well as the required A&H Certification.*
Attachment(s):	*TN Smart Choice Actuarial Memorandum.pdf* *TN Actuarial Certification.pdf*

Satisfied - Item:	Claims Trend Graph
Comments:	Please see the attached exhibit.
Attachment(s):	Claims Trend Graph.pdf

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate Manual	TN HUMD IND 2014	New		TN Smart Choice Rate Manual.xlsm,	07/23/2013 By: Benjamin Ligocki

Conclusion:

Thank you for your review.

Sincerely,

Benjamin Ligocki

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**	

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/10/2013
Submitted Date	07/10/2013

Dear Vicky Stotzer,

Introduction:

Thank you for your review of our filing.

Response 1

Comments:

We have removed the brackets from the face page and from the Eligibility section where we had proposed to include or omit language based on whether the policy was to be sold on the exchange or off. This form will only be used on the exchange, so we have deleted all references to the application. See also the Eligibility Section which has had application references deleted.

Related Objection 1

Applies To:

- Policy Cover, TN HUMD IND 2014 (Form)

Comments: If the important notice is variable due to the on/off exchange language, please separate and have one for off and one for the on exchange.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: HUMA-128968624 **State Tracking #:** H-130807 **Company Tracking #:**

State: Tennessee **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Individual Dental Insurance
Project Name/Number: Stand-alone Dental/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Policy Cover	TN HUMD IND 2014	POL	Initial		48.700		Date Submitted: 07/10/2013 By: Nancy Anderson
Previous Version								
1	*Policy Cover*	*TN HUMD IND 2014*	*POL*	*Initial*		*48.700*	*TN HUMD IND 2014.pdf*	*Date Submitted: 06/04/2013 By: Nancy Anderson*

No Rate/Rule Schedule items changed.

Response 2

Comments:

Regarding the Orthodontic benefit, the Q and A from CMS left the definition of Medically Necessary Orthodontia up to the discretion of the carrier. Our policys Orthodontia benefit reflects our definition of medically necessary orthodontia.

Q12: What is the definition of medically-necessary orthodontia?
A12: Issuers will be responsible for developing standards to define medically-necessary orthodontia.

Related Objection 2

Applies To:

- Pediatric Dental Benefit, HUMD IND PED BEN 2014 (Form)

Comments: Orthodontic treatment, subject to clinical review and when as a result of congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. Services include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care. Limited to one per lifetime.

This is not what is in the FEDVIP benefit. Please see the proper benefit, after 2 years you must cover this for non-medically necessary.

Changed Items:

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

We appreciate your time and attention to this filing. If you have any questions or need additional information please feel free to contact me.

Sincerely,

Nancy E. Anderson
Humana
500 W. Main Street
Louisville, KY 40202
(502) 580-4230
nanderson1@humana.com

Sincerely,
Nancy Anderson

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Note To Filer

Created By:

Art Lucker on 07/22/2013 09:35 AM

Last Edited By:

Art Lucker

Submitted On:

07/22/2013 09:35 AM

Subject:

Extension until July 24, 2013

Comments:

The extension granted until July 24, 2013

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Note To Reviewer

Created By:

Benjamin Ligocki on 07/19/2013 01:07 PM

Last Edited By:

Benjamin Ligocki

Submitted On:

07/19/2013 01:07 PM

Subject:

Request for Extension

Comments:

I would like to request an extension of time to respond to the objection received on 7/12/13. Can the respond by date please be moved to 7/24/13?

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Note To Filer

Created By:

Brian Hoffmeister on 06/07/2013 10:27 AM

Last Edited By:

Brian Hoffmeister

Submitted On:

06/07/2013 10:28 AM

Subject:

Rating Areas

Comments:

Tennessee has 8 rating areas starting in 2014, please go to http://www.state.tn.us/insurance/documents/Comm_ltr_hhs020713.pdf to view the Commissioner's letter regarding this. Your rating areas, rates and rating factors do not comply with this requirement and need to be corrected.

Also, the attachment, TN Smart Choice Rate Manual, needs to be saved as an .xls file and attached to the Supporting Documentation Tab. We are unable to open .xlsm files in SERFF.

SERFF Tracking #: HUMA-128968624 **State Tracking #:** H-130807 **Company Tracking #:**

State: Tennessee **Filing Company:** Humana Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: Individual Dental Insurance
Project Name/Number: Stand-alone Dental/

Form Schedule

Lead Form Number: TN HUMD IND 2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 07/30/2013	Policy Cover	TN HUMD IND 2014	POL	Initial		48.700	
2	Approved 07/30/2013	Table of Contents	HUMD IND TOC 2014	POL	Initial		48.700	HUMD IND TOC 2014.pdf
3	Approved 07/30/2013	Preferred Provider Organization	HUMD IND PPO 2014	POL	Initial		48.700	HUMD IND PPO 2014.pdf
4	Approved 07/30/2013	Adult Dental Benefit	TN HUMD IND ABEN 2014	POL	Initial		48.700	TN HUMD IND ABEN 2014.pdf
5	Approved 07/30/2013	Pediatric Dental Benefit	TN HUMD IND PED BEN 2014	POL	Initial		48.700	F-GN Pediatric Dental Benefit .pdf
6	Approved 07/30/2013	Limitations & Exclusions	HUMD IND L&E 2014	POL	Initial		48.700	HUMD IND L&E 2014.pdf
7	Approved 07/30/2013	Eligibility	HUMD IND ELIG 2014	POL	Initial		48.700	HUMD IND ELIG 2014.pdf
8	Approved 07/30/2013	Changes to Your Coverage	HUMD IND CHG 2014	POL	Initial		48.700	HUMD IND CHG 2014.pdf
9	Approved 07/30/2013	Premium Payment	TN HUMD IND PREM 2014	POL	Initial		48.700	TN HUMD IND PREM 2014.pdf
10	Approved 07/30/2013	Termination	HUMD IND TER 2014	POL	Initial		48.700	HUMD IND TER 2014.pdf

SERFF Tracking #: *HUMA-128968624* ***State Tracking #:*** *H-130807* ***Company Tracking #:***

State: *Tennessee* ***Filing Company:*** *Humana Insurance Company*
TOI/Sub-TOI: *H10I Individual Health - Dental/H10I.000 Health - Dental*
Product Name: *Individual Dental Insurance*
Project Name/Number: *Stand-alone Dental/*

Lead Form Number: TN HUMD IND 2014

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
11	Approved 07/30/2013	General Provisions	TN HUMD IND GP 2014	POL	Initial		48.700	TN HUMD IND GP 2014.pdf
12	Approved 07/30/2013	Definitions	HUMD IND DEF 2014	POL	Initial		48.700	HUMD IND DEF 2014.pdf
13	Approved 07/30/2013	Outline of Coverage	TN HUMD-IND-OC-2014	OUT	Initial		48.700	TN-HUMD-IND-OC-2014.pdf
14	Approved 07/30/2013	Policy Face Page	TN HUMD IND 2014	POL	Initial		48.700	TN HUMD IND 2014.pdf
15	Approved 07/30/2013	Eligibility	TN HUMD IND ELIG 2014	POL	Initial		48.700	TN HUMD IND ELIG 2014.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

TABLE OF CONTENTS

Contents **Section number**

PREFERRED PROVIDER ORGANIZATION

PPO Provisions
What is a Preferred Provider Organization (PPO)?
A PPO is a network or group of *providers* who are contracted to furnish, at *negotiated fees*, dental *services* for *you* and *your* covered *dependents* under this *policy.*

Reasons to use a PPO provider

1. *We* negotiate fees for dental *services*. The *negotiated fees* may lower costs for *covered persons* when an *in-network provider* is used.
2. *Covered persons* may receive a better *benefit* and out-of-pocket expenses are lowered.
3. There is a wide variety of *providers* in the PPO network to provide dental care.

You and *your* covered *dependents* have the freedom to choose the *provider* of choice. However, *maximum benefits* will be received by seeing a *network provider*. A *non-network provider* may *balance bill you* for any *expense incurred* that exceeds *our reimbursement limit*.

How to select a provider
A list of *network providers* is available on *our* Website and is updated daily. If *you* do not have Internet access, *provider* lists are available by calling *us*. *Our* telephone number and Website address are listed on the back of *your* dental *identification card*.

If *you* or a *covered person* are traveling or need *emergency* care and are unable to access care from a *network provider*, *benefits* will be paid at the *non-network* level.

ADULT DENTAL BENEFIT

This *policy* refers to various dollar and percentage amounts, as well as other *benefit* information that may be specific to *covered person(s)*. *You* selected some of these *benefits* when *you* applied for coverage under this *policy*. Some of the provisions herein require automatic changes. For example, when a *dependent* no longer qualifies as a *dependent* under this *policy*, that *dependent's* coverage will terminate.
Please read this *policy* to fully understand all terms, conditions, limitations and exclusions that apply. This Adult Dental Benefit section describes dental *benefits* that will be considered *covered expenses* for *covered persons* age 19 and older.

Schedule of adult dental benefits

Class I services:
Network provider: *Benefits* are paid at 100%.
Non-network provider: *Benefits* are paid at 70% after the *non-network provider deductible* has been met.

Class II services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Dental deductible:

Individual deductible:
$100 per *year* per *covered person* when *services* are provided by a *network provider*.

$100 per *year* per *covered person* when *services* are provided by a *non-network provider*.

Annual maximum benefit – $1,000 per *covered person*.

Network Provider Plan Year Out-of-Pocket Maximum applies only to the "Pediatric Dental Benefit" section.

We pay *benefits* for *covered expenses* as explained in this section. *Benefits* for the *services* explained below are limited to the *benefit* maximum shown above.

The following *services* are considered as integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense*.

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Study models/diagnostic casts;
5. Tissue preparation associated with impression or placement of a restoration;
6. *Treatment plans*;
7. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
8. Nitrous oxide; and
9. Irrigation.

ADULT DENTAL BENEFIT

Class I Services

1. Periodic oral evaluations two every *year*. *Benefit* is not available when a comprehensive oral evaluation is performed.
2. Comprehensive oral evaluation – one every three *years*. *Benefit* is not available when a periodontal evaluation is performed.
3. Limited and problem focused oral evaluations – one every *year*.
4. Detailed and extensive oral evaluation – problem focused, by report – one every *year*.
5. Re-evaluation – limited problem focused – one every *year*.
6. Periodontal evaluations - one every three *years*. *Benefit* allowed only for a *covered person* showing signs or symptoms of periodontal disease and for *covered persons* with risk factors such as smoking, diabetes or related health issues. No *benefit* is payable when performed with a cleaning (prophylaxis). *Benefit* is not available when a comprehensive oral evaluation is performed.
7. Cleaning (prophylaxis), including all scaling and polishing procedures – two per *year*.
8. Bitewing X-rays – one set per *year*.
9. Posterior – anterior or lateral skull and facial bone survey film – one every *year*.
10. Other X-rays including intra-oral periapical and occlusal and extra-oral X-rays only to diagnose specific treatment.

Class II Services

1. Amalgam restorations (fillings) – limited to one per tooth every two *years.* Multiple restorations on one surface are considered one restoration.
2. Composite restorations (fillings) limited to one per tooth every two *years*. Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
3. Non-cast pre-fabricated stainless steel and esthetic stainless steel and resin crowns that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate *service* and will be payable as a comparable non-cast pre-fabricated stainless steel crown. *You* will be responsible for the remaining *expense incurred*. Limited to one per tooth every five years.
4. Treatment for initial *palliative* care of pain and/or injury. *Services* include *palliative* procedures for treatment to the teeth and supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service*, except X-rays and/or problem focused exam, is provided during the same visit.
5. Extractions - erupted tooth or exposed root limited to once per tooth per lifetime.
6. Complex oral surgery *services* as follows – limited to one per tooth per lifetime:
    a. Surgical extractions.
    b. Trim or remove over growth or non-vital tissue or bone.
    c. Removal of tooth or root from sinus and closing opening between mouth and sinus.
    d. Excision or removal of malignant oral cysts or tumors.
    e. Bone, cartilage or synthetic grafts.
    f. General anesthesia or conscience sedation subject to *clinical review* and

administered by a *provider* in conjunction with a covered oral surgical procedure and/or the *covered person* has a dental *service*. General anesthesia will not be covered for the following reasons: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.

PEDIATRIC DENTAL BENEFIT

This Pediatric Dental Benefits section describes the dental *benefits* that will be considered *covered expenses* for *covered persons* under the age of 19. There are no Pediatric Dental *Benefits* available for *covered persons* age 19 or older. In the event of any conflict between this Pediatric Dental Benefits section and other provisions contained in this *policy*, the provisions of this Pediatric Dental Benefits section shall control.

Notwithstanding any other provisions of this *policy*, *covered expenses* under this section are not covered under any other provision of this *policy*. Any amount in excess of the maximum amount provided under this section, if any, is not covered under any other provision in this *policy*.

All terms used in this section have the same meaning given to them in this *policy*, unless otherwise specifically defined in this section.

Schedule of pediatric dental benefits

This summary provides an overview of Pediatric Dental Benefits. Refer to the "Pediatric Dental Benefits" provision for detailed descriptions, including additional limitations or exclusions.

Benefits for Pediatric Dental Benefits will be paid at the *coinsurance* percentage shown on a maximum allowable fee basis after any applicable *deductible* has been met.

Class I Services:
Network provider: *Benefits* are paid at 100%.
Non-network provider: *Benefits* are paid at 70% after the *non-network provider deductible* has been met.

Class II Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Class III Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Class IV Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Dental Deductible:

Individual deductible:
$100 per *year* per *covered person* when *services* are provided by a *network provider*.

$100 per *year* per *covered person* when *services* are provided by a *non-network provider*.

Network Provider Plan Year Out-of-Pocket Maximum:
Once the *out-of-pocket maximum* is met, *network provider covered expenses* are paid at 100%.

PEDIATRIC DENTAL BENEFIT

Non-network provider services do not accumulate toward the *out-of-pocket maximum*.

Out-of-pocket maximum for a policy with one covered child:
$700

Out-of-pocket maximum for a policy with two or more covered children:
$700 per individual child: or
$1400 combined for all children

Pediatric dental benefits

We pay pediatric dental *benefits* on *covered expenses* as explained in this "Pediatric Dental Benefits" provision.

Class I Services:

1. Periodic oral evaluations - two every *year*. *Benefit* is not available when a comprehensive oral evaluation is performed.
2. Comprehensive oral evaluation – one every three *years*. *Benefit* is not available when a periodontal evaluation is performed.
3. Limited and problem focused oral evaluations - one every *year*.
4. Oral evaluation for a patient under three years of age and counseling with primary caregiver – two every *year.*
5. Detailed and extensive oral evaluation – problem focused, by report – one every *year*.
6. Re-evaluation – limited problem focused – one every *year*.
7. Periodontal evaluations - one every three years. *Benefit* allowed only for *covered persons* showing signs or symptoms of periodontal disease and for *covered persons* with risk factors such as smoking, diabetes or related health issues. No *benefit* is payable when performed with a cleaning (prophylaxis). *Benefit* is not available when a comprehensive oral evaluation is performed.
8. Cleaning (prophylaxis), including all scaling and polishing procedures – two every *year*. *Benefit* is not available if periodontal maintenance has been previously provided.
9. Intra-oral complete series X-rays (14 films, including bitewings) or panoramic X-ray – one every five *years*. If the total cost of periapical and bitewing X-rays exceeds the cost of a complete series of X-rays, the plan will consider these as a complete series.
10. Bitewing X-rays – one set every six months.
11. Posterior – anterior or lateral skull and facial bone survey film – one every *year.*
12. Other X-rays including intra-oral periapical & occlusal and extra-oral X-rays – only to diagnose specific treatment.
13. Topical fluoride treatment provided to *covered persons* age 14 and younger. *Service* is payable two times every *year.*
14. Sealants – application provided to *covered persons* age 18 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth every 36 months.
15. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *covered persons* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
16. Recementation of space maintainer- limited to two per *year*.
17. Removal of fixed space maintainer. Limited to once per lifetime.

Class II Services:

PEDIATRIC DENTAL BENEFIT

1. Restorative *services* as follows:
    a. Amalgam restorations (fillings) – limited to one per tooth every two *years*. Multiple restorations on one surface are considered one restoration.
    b. Composite restorations (fillings) limited to one per tooth every two *years*. Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
    c. Gold foil restorations (fillings) limited to one per tooth every two *years*. Gold foil restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
    d. Pin retention – per tooth in addition to restoration that is not in conjunction with core build-up.
    e. Non-cast pre-fabricated stainless steel and esthetic stainless steel and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate *service* and will be payable as a comparable non-cast pre-fabricated stainless steel crown. *You* will be responsible for the remaining *expense incurred*. Limited to one per tooth every five *years*.
2. Simple oral surgical *services* as follows:
    a. Extraction - coronal remnants of a deciduous tooth.
    b. Extraction - erupted tooth or exposed root.
3. Complex oral surgery *services* as follows – limited to one per tooth per lifetime:
    a. Surgical extractions.
    b. Bone smoothing.
    c. Trim or remove over growth or non-vital tissue or bone.
    d. Removal of tooth or root from sinus and closing opening between mouth and sinus.
    e. Surgical access of an un-erupted tooth.
    f. Mobilization of erupted or malpositioned tooth to aid eruption; or surgical reposition of teeth.
    g. Excision or removal of malignant oral cysts or tumors.
    h. Bone, cartilage or synthetic grafts.
    i. General anesthesia or conscience sedation subject to *clinical review* and administered by a *provider* in conjunction with a covered oral surgical procedure and/or the *covered person* has a dental *service*. General anesthesia will not be covered for the following reasons: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.
    j. Reduction of dislocation for temporomandibular joint dysfunction.
4. Miscellaneous *services* as follows:
    a. *Emergency* care – treatment for the initial *palliative* dental care of pain or an accidental *dental injury* to teeth or supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service*, except X-rays and/or problem focused oral evaluation, is provided during the same visit.
    b. Diagnostic consultation – *service* provided by a *provider* or physician not providing the treatment. Coverage is subject to *clinical review*.

Class III Services

1. Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations. The

existing major restoration may be replaced only if:

a. It has been at least five *years* since the prior insertion and is not, and cannot be made serviceable;
b. It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the oral cavity; or
c. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis necessitates the replacement of the prosthesis.

2. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement of filling material. *Covered expenses* include inlays, onlays, crowns, veneers, core build-ups, and posts, implant supported crowns and abutments. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up. Limited to one per tooth every five *years*.

3. Periodontic *services* as follows:

a) Periodontal scaling and root planing. Limited to a maximum of one every 24 months and four quadrants per visit. Additional quadrants available seven days following completion of initial quadrants.
b) Periodontal maintenance (at least 30 days following periodontal therapy) limited to two per *year*. *Benefit* is not available when a cleaning (prophylaxis) is performed.
c) Periodontal and osseous surgery, including bone replacement, tissue regeneration, and/or graft procedures, limited to one per quadrant every36 months. If more than one surgical *service* is performed on the same day, *we* will consider only the most inclusive *service* performed as a *covered expense*.
d) Occlusal adjustment only when performed in conjunction with periodontal surgery limited to one per quadrant every three *years.*

Separate fees for pre and post-operative care and re-evaluation within three months are not covered.

4. Endodontic *services* as follows:

a) Root canal therapy, including root canal treatments and root canal fillings – for permanent and primary teeth. Any test, intraoperative, X-ray, exam, laboratory or any other follow-up care is considered integral to root canal therapy.
b) Root canal retreatment, including root canal treatments and root canal fillings - for permanent and primary teeth. Any test, intraoperative, X-ray, exam, laboratory or any other follow-up care is considered integral to root canal therapy.
c) Periradicular surgery, including apicoectomy, root amputation, tooth reimplantation, and/or surgical isolation for permanent teeth.
d) Partial pulpotomy for apexogenesis for permanent teeth.
e) Vital pulpotomy – procedure available to permanent and primary teeth.
f) Pulp debridment, pupal therapy (resorbable) – for permanent and primary teeth, one time per tooth per lifetime.
g) Apexification/recalcification - procedure available to permanent and primary teeth, one per tooth per lifetime.

5. Prosthodontics *services* as follows:

a) Repairs of bridges, complete dentures, immediate dentures, partial dentures, and

crowns.

b) Denture adjustments – when done by a *provider* other than the one providing the denture, or adjustments performed more than six months after initial installation - two every *year*.

c) Initial placement of bridges, complete dentures, immediate dentures and partial dentures - one every five *year(s)*. *Covered expenses* include pontics, inlays, onlays, crowns, relines, rebases, and/or adjustments one every five *year*s. *Services* include relines, rebases, and/or adjustments limited to six months after installation and are payable only for replacement of permanent and primary teeth.

d) Replacement of bridges, complete dentures, immediate dentures, and partial denture. The existing prosthesis can be replaced only if:

i. It has been at least five *years* since the prior insertion and is not, and cannot be made serviceable;

ii. It is damaged beyond repair as a result of an *accidental injury* while in the oral cavity; or

iii. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis requires the replacement of the prosthesis.

These *services* are covered on permanent teeth.

e) Tissue conditioning – one every three *years*.

f) Post and core build-up in addition to partial denture retainers with or without core build-up - one every five *years.*

6. Implant *services* are subject to *clinical review*. Dental implants and related *services* including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures are covered subject to *clinical review*. Implant supported complete or partial dentures limited to one every five *years*. All other *services* limited to one every five *years*. No *benefit* will be allowed if it is determined that a standard prosthesis or restoration will satisfy the dental need.

7. Miscellaneous *services* as follows:
   a. Recementing of inlays, onlays, crowns, and bridges.
   b. The initial installation of fixed and removable appliances to inhibit thumb sucking and other harmful habits. Separate adjustment expenses will not be covered.

Class IV Services:

Orthodontic treatment, subject to *clinical review* and when as a result of congenital or developmental malformations. *Services* include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care. No benefit is payable for orthodontic treatment for cosmetic purposes.

Integral service

Additional charges related to materials or equipment used in the delivery of dental care. The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense.*

1. Local anesthetics;
2. Bases;
3. Pulp caps;
4. Study models/diagnostic casts;
5. *Treatment plans*;

6. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
7. Nitrous oxide;
8. Irrigation;
9. Tissue preparation associated with impression or placement of a restoration.

Pediatric dental limitations & exclusions

In addition to the LIMITATIONS AND EXCLUSIONS section and any exclusions listed in this "Pediatric Dental Benefits" section, the following limitations and exclusions also apply to pediatric dental *benefits*:

1. Any expense arising from the completion of forms.
2. Any *service we* consider *cosmetic dentistry* unless it is required as a result of an *accidental injury* sustained while a *covered person* is covered under this *policy*. *We* consider the following procedures to be *cosmetic dentistry*:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
   - Any *service* performed primarily to improve appearance;
   - Characterizations and personalization of prosthetic devices; or
   - Orthodontic treatment for crowded dentitions, excessive spacing between teeth, and/or having horizontal/vertical (overjet/overbite) discrepancies.
3. Charges for:
   - Any type of implant and all related *services*, including crowns or the prosthetic device attached to it including the removal of implants, unless specified in this *policy*.
   - Precision or semi-precision attachments.
   - Overdentures and any endodontic treatment associated with overdentures.
   - Other customized attachments.

   a. Any *services* for 3D imaging (cone beam images).
   b. Additional charges related to materials or equipment used in the delivery of dental care.
   c. Charges for treatment rendered by family member or person who resides with the *covered person*.

4. Any *service* related to:
   - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis.
5. Orthodontic *service*s unless specified in this "Pediatric Dental Benefit" section.
6. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service.*
7. Any non-emergent dental *expenses incurred* for *services* rendered outside of the United

States.

8. Temporary and interim dental *services;*
9. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
10. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
11. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
12. Any *services* for orthognathic surgery.
13. Any *services* for destruction of lesions by any method.
14. Any *services* for tooth transplantation.
15. Any *services* for removal of a foreign body from the oral tissue or bone.
16. Any *services* for reconstruction of surgical, traumatic or congenital defects of the facial bones.
17. Any *services* generally considered to be medical *services*.
18. Any separate fees for pre and post-operative *services.*

PEDIATRIC DENTAL BENEFIT

Pediatric dental definitions

The following definitions are in addition to other definitions found in this *policy*.

Covered service: A *service* that is:

1. Ordered by a *provider*;
2. For the *benefits* described, subject to all terms, provisions, limitations and exclusions of this *policy*; and
3. Incurred when a *covered person* is insured for that *benefit* under this *policy* on the *expense incurred date*.

Expense incurred date: The date on which the teeth are prepared for fixed bridges, crowns, inlays, onlays or veneers:

1. The final impression is made for dentures or partials;
2. The pulp chamber of a tooth is opened for root canal therapy;
3. Periodontal surgery is performed; or
4. The *service* is performed for *services* not listed above.

Out-of-pocket maximum: The maximum amount of *covered expense* a *covered person* or *policyholder* pays each *year* for *network provider services* covered under this *policy*. This amount includes *coinsurance* and *deductible* but does not include:

1. Amounts over the *reimbursement limit*;
2. Non-covered *services*;
3. Other *policy* limits: or
4. *Non-network provider services*.

There are separate *out-of-pocket maximums* depending on the number of children covered on this *policy*. Refer to the “Schedule of pediatric dental benefits” provision for the amount.

LIMITATIONS AND EXCLUSIONS (ALL SERVICES)

In addition to the limitations and exclusions listed in “Adult Dental Benefit” and “Pediatric Dental Benefit” sections, as applicable, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while a *covered person* qualifies for any worker’s compensation or occupational disease act or law, whether or not the *covered person* applied for coverage.
2. *Services*:
   A. That are free or that a *covered person* would not be required to pay for if they did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   B. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   C. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury.*
3. Any loss caused or contributed by:
   A. War or any act of war, whether declared or not;
   B. Any act of international armed conflict; or
   C. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the *provider*.
6. Any *service we* consider *cosmetic dentistry* unless it is required as a result of an *accidental injury* sustained while the *covered person* is covered under this *policy*. *We* consider the following *cosmetic dentistry* procedures:
   A. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
   B. Any *service* to correct congenital malformation;
   C. Any *service* performed primarily to improve appearance; or
   D. Characterizations and personalization of prosthetic devices.
7. Charges for:
   A. Precision or semi-precision attachments;
   B. Overdentures and any endodontic treatment associated with overdentures; or
   C. Other customized attachments.
8. Any *service* related to:
   A. Altering vertical dimension of teeth;
   B. Restoration or maintenance of occlusion;
   C. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   D. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   E. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.

11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.

LIMITATIONS AND EXCLUSIONS (ALL SERVICES)

12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in "Adult Dental Benefit**"** and "Pediatric Dental Benefit" section, as *applicable*.
14. Any *service* that *we* determine:
    A. Is not an eligible *benefit* based on *clinical review*;
    B. Does not offer a favorable prognosis;
    C. Does not have uniform professional endorsement; or
    D. Is deemed to be experimental or investigational in nature.
15. Orthodontic *service*s unless otherwise stated in this *policy*.
16. Any *expense incurred* before the *covered person's effective date* or after the date the *covered person's* coverage under this *policy* terminates.
17. *Services* provided by someone who ordinarily lives in the *covered person's* home or who is a *family member.*
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, *treatment plans*, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service.*
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull unless otherwise stated in this *policy*; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
25. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
26. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

ELIGIBILITY

Dependent coverage

Eligibility date: If the *primary insured* is covered, the *primary insured's dependent* is eligible for coverage:

1. On the date the *primary insured* is eligible for coverage; or
2. On the date a *special enrollment period* applies.

Adding dependents
If a child is born to a *policyholder*, or any *covered person*, a *policyholder* adopts a child, or a child is placed with the *policyholder* for the purpose of adoption *we* must be notified of the event in writing and receive any required premium within 31 days (60 days if coverage was purchased through an *exchange*) of the event.

If *we* do not receive notice and premium for the first 31 days (60 days if coverage was purchased through an *exchange*) and forward the child must wait to enroll for coverage during the next *open enrollment period*, unless such child becomes eligible for a special enrollment as specified in the "Special Enrollment" provision.

For a *dependent* not falling under the previous paragraphs the *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless the *dependent* becomes eligible for a special enrollment as specified in the "Special Enrollment" provision.

Upon *our* receipt of the [completed application and] premium, an *effective date* will be assigned. A *dependent* child is eligible to apply if they are under age [26 – 31].

Effective date of dependent changes

a. Coverage for a newborn or adopted child will be effective on the date of birth, placement or adoption, provided *you* [complete an application and] remit the premium within 31 days (60 days if coverage was purchased through an *exchange*) of the child's date of birth or adoption.
b. If *we* receive [the application and] any required premium more than 31 days (60 days if coverage was purchased through an *exchange*) after the newborn's date of birth or the child's adoption or placement for adoption, such child will be covered on the effective date assigned.

For changes for other *dependents* an effective date will be assigned upon *our* receipt of a completed application and any required premium.

Application: If *you* have any questions in regard to applying, for *dependent* coverage, please contact *us.*

A *dependent's* effective date cannot occur before the *insured's effective date* of coverage.

CHANGES TO YOUR COVERAGE

A. Special enrollment

A *special enrollment period* is available if the following apply:

1. A *covered person* has a change in family status due to:
    A. Marriage;
    B. Divorce;
    C. Legal separation;
    D. The birth of a natural born child;
    E. The adoption of a child or placement of a child with the *policyholder* for the purpose of adoption;
    F. Death of the *policyholder*;
    G. For a *covered person* who purchased coverage through an *exchange*, any other event as determined by the *exchange*; or
    H. The *covered person* furnishes proof of the event that is satisfactory to *us* and enrolls within 60 days of the date of the special enrollment event.
2. Coverage under this *policy* terminates due to:
    A. A *dependent* child attains the limiting age; or
    B. For a *covered person* who purchased coverage through an *exchange*, any other event as determined by the *exchange*; or
    C. The *covered person* furnishes proof of the event that is satisfactory to *us* and enrolls within 60 days of the date of the special enrollment event.
3. A *dependent* did not enroll for coverage under this *policy* when first eligible due to:
    A. Being covered under an employer sponsored health insurance plan and coverage under that plan terminates;
    B. Not a citizen of the United States and subsequently gains such lawful status;
    C. For a *covered person* who purchased coverage through an *exchange*, any other event as determined by the *exchange*; or
    D. The dependent furnishes proof of the event that is satisfactory to *us* and enrolls within 60 days of the date of the special enrollment event.

4. For a *covered person* who purchased coverage through an *exchange*, any other event as determined by the *exchange*. The *covered person* must enroll within 60 days of the special enrollment event date.

The effective date of coverage for a *covered person* who requests coverage due to a special enrollment event will be assigned.

A *special enrollment period* is not available if coverage terminated due to non-payment of premium or coverage is rescinded.

B. Changes in benefits

You may call or write *us* to request additional, increased or decreased *benefits*. If the additional *benefits you* request are available, as determined and approved by *us*, the *benefits* will become effective on the date *we* approve the change.

C. Change in state of residence

If *you* move outside of this *policy's* service area or move out of the state where this *policy* was issued, *we* will terminate this *policy*. If a *covered person* moves outside of

this *policy's* service area or moves out of the state where this *policy* was issued, coverage for that *covered person* will terminate. See the "Termination" section for the events that will cause this *policy* and/or a *covered person's* coverage to end. Such change will be effective on the date *we* assign.

D. Child-only coverage

The parent or legal guardian in whose name coverage is issued is considered the *primary insured*. In the case of child-only coverage, as a parent or legal guardian, *you* have contracted on behalf of *your dependent* for the *benefits* described in this *policy*. It is *your* responsibility to assure *your dependent's* compliance with any and all terms and conditions outlined in this *policy*.

To add a *dependent* child to child-only coverage, follow the procedures listed above.

E. Our rights to make changes to this policy

We have the right to make certain changes to this *policy.*

F. Changes we will make without notice to you

If a change is required by a state or federal law or government division, *we* can make the change at any time without notice to *you.*

G. Changes when we will notify you

We also can make changes to this *policy* on the premium due date or upon separate notice, provided *we* send *you* a written explanation of the change 31 days prior to its effect. All such changes will be made in accordance with state law. *Your* continued payment of premium will stand as proof of *your* agreement to the change.

H. How do you know these are our changes?

No modification or amendment to this *policy* will be valid unless approved by the President, Secretary or a Vice-President of *our* company. No agent has authority to modify this *policy*, waive any of the *policy* provisions, extend the time for premium payment or bind *us* by making any promise of representation.

PREMIUM PAYMENT

A. Premium payment

Your Duty to Pay Premium
You must pay the required premium to *us* as it becomes due. Failure to do so will result in termination of coverage.

The first premium is due on the *effective date*. Subsequent premiums are due on the first day of each premium period. Premium period means monthly, quarterly, semi-annually or annually. All premiums are payable to *us* at *our* address.

Grace Period
You have 31 days (90 days if coverage was purchased through an *exchange*, *you* paid at least one month of premium and received advance payment of the premium tax credit) from the premium due date to remit the required funds. If premium is not paid *we* will terminate the insurance as of the last day of the premium period for which premium was paid (the last day of the first month of the grace period if *you* purchased coverage through an *exchange* and received advance payment of the premium tax credit).

Changes to Your Premium
Premium may change when:
- Family members are added or deleted;
- Coverage is increased or decreased;
- A *covered person* moves to a different zip code or county;
- Premium payment method is changed;
- A new rate table applies;
- Any *covered person's* age increases;
- Any *covered person's* rating classification changes; or
- A misstatement on the application form results in the proper amount due not being charged.

We will notify *you* of any premium change within 30 days. *Your* continued payment of premium will stand as proof of *your* agreement to the change

Return of premium/rescission
In no event, except for the following reasons will premium be returned:
1. The *policyholder* returns the *policy* as described in the "Right to Return Policy" provision on the cover of this *policy*;
2. Rescission of coverage as described in the "Incontestability" provision in the "General Provisions" section; or
3. The *policyholder* requests coverage to terminate; provided coverage has been continuously in force for at least 12 months from the *effective date* of this *policy*; and premium has been paid for any period of time after the termination date.

TERMINATION

Terminating coverage
Your insurance coverage may end at any time, as stated below. Coverage terminates on the earliest of the following events:

1. Failure to pay premium by the required due date;
2. The end of the month *you* enter the military fulltime;
3. The end of the month *you* or a *covered person* are covered on a group plan;
4. The date a *covered person* commits fraud or intentional misrepresentation of a material fact, as determined by *us*;
5. For a *dependent*, the end of the month *your* insurance terminates;
6. For a *dependent,* the end of the month he/she no longer meets the definition of a *dependent*;
7. The end of the month following *your* request that insurance be terminated for *you* and/or *your dependents* given that coverage has been continuously in force for at least 12 months from the *effective date* of this *policy*, unless *you* are eligible for a *special enrollment period*;
8. The end of the month *you* enroll in another dental insurance plan during an *open enrollment period*;
9. The end of the month that a change in *your* legal residence from the state in which this *policy* was issued occurs;
10. The end of the month *you* move outside the service area, as determined by *us*. Call the telephone number on *your ID card* for this *policy's* service area; or
11. If coverage was purchased through an *exchange*:
    a. *You* cease to be eligible for coverage through an *exchange*; or
    b. This *policy* ceases to be a *qualified health plan* and is decertified by an *exchange*.

    If coverage was purchased through an *exchange*, the *exchange* will initiate the termination and notify *us* of the event. The termination date will be assigned.

If coverage under this *policy* is terminated due to fraud or an intentional misrepresentation of a material fact, a 30-day advance written notice of the termination will be provided.

Your duty to notify us
You are responsible to notify *us* of any of the events stated above which would result in termination of a *covered person*.

If *we* accept premium for any *covered person* extending beyond the date, age or event specified in this provision as a reason for termination, then coverage for the *covered person* will continue during the period for which an identifiable premium was accepted, except where such acceptance of premium was based on misstatement of age.

If *you* fail to provide timely notification of these events, the termination date and the period for which premium refund (if any) will be calculated, will be determined based on when *we* should have received the notification, as determined by *us*.

GENERAL PROVISIONS

A. How this plan works

General benefit payments

We pay *benefits* for *covered expenses,* as stated in any applicable "Adult Dental Benefit**"** and "Pediatric Dental Benefit" sections, and according to any riders that are part of this *policy.* All *benefits we* pay are subject to all conditions, limitations, exclusions, and maximums of this *policy*.

When a *covered person* receives a *service*, *we* will determine if it qualifies as a *covered service*. Any *service* qualifying as a *covered service* must not be excluded by the terms of this *policy* or limited by a waiting period. After determining that the *service* is a *covered service*, *we* will pay *benefits* as follows:

1. *We* will determine if the *service* was rendered by a *network* or *non-network provider*. If rendered by a *network provider, we* will determine the *negotiated fee* amount. If rendered by a *non-network provider*, *we* will determine the *reimbursement limit*. The result is the total amount of eligible *expenses incurred* related to a particular *service.*
2. *We* will review the eligible *expenses incurred*, against any *policy* or *benefit* maximum which may apply to a particular *service*.
3. *We* will determine if the *covered person* has met his or her *deductible*. If he or she has not, for any *services* subject to the *deductible*, *we* will subtract any amount the *covered person* is required to pay as part of the *deductible*; and
4. *We* will make payment for the remaining eligible *expense incurred* by *you* or the *provider* based on *our coinsurance* for that *service*.

Deductibles

The *deductible* is the amount shown within the "Pediatric Dental Benefit" and "Adult Dental Benefit" sections, as applicable, that the *covered person* must pay in *covered expenses* before *we* pay any *coinsurance*.

How do you know when you no longer have to pay toward the deductible?

Each *year*, when the total eligible *covered expenses* a *covered person* has incurred reaches the individual *deductible* amount, the individual *deductible* has been met for that *covered person*.

Benefit maximums

The amount *we* pay for *services* under the "Adult Dental Benefit" section is limited to a *maximum benefit*. *We* will not make *benefit* payments that are more than the *maximum benefit*.

B. Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, y*ou* or the *covered person's provider* submit a dental *treatment plan* for *us* to review before the treatment. The dental *treatment plan* should consist of:

1. A list of *services* to be performed using the American Dental Association nomenclature and codes;
2. The *covered person's provider's* written description of the proposed treatment;
3. Supporting pretreatment X-rays showing the *covered person's* dental needs;
4. Itemized cost of the proposed treatment; and

5. Any other appropriate diagnostic materials that *we* may request.

An estimate for *services* is not a guarantee of what *we* will pay. It tells *you* and the *provider* in advance about the *benefits* payable for the *covered expenses* in the *treatment plan*. *We* will notify *you* and the *covered person's provider* of the *benefits* payable based on the submitted *treatment plan*.

An estimate for *services* is not necessary for *emergency* care.

Visit *our* Website at [Humana.com] or call the Customer Service telephone number on *your ID card* to find out what will be a *covered expense* before treatment is received.

Alternate services
If two or more *service*s are considered to be acceptable to correct the same dental condition, the *benefits* payable will be based on the *covered expenses* for the least expensive *covered service* that produces a professionally satisfactory result, as determined by *us.* Payment will be limited to the *reimbursement limit* for the least costly *covered service* and subject to any applicable *deductible* and *coinsurance*. *You* will be responsible for paying the excess amount.

Process and timing
Subject to the *covered person's* eligibility of coverage under this *policy*, the pretreatment plan is valid for 90 days after the date *we* notify *you* and the *provider* of the *benefits* payable for the proposed *treatment plan*. If treatment is to commence more than 90 days after the date *we* notify *you* and the *provider* of the *benefits* payable for the proposed *treatment plan*, a new *treatment plan* must be submitted to *us.*

C. Claims

A. How we pay claims

Identification numbers
You received an *identification card* showing *your* name, and [member] identification number. Show this *ID card* to the *provider* when *services* are received.

Claim forms
We do not require a standard claim form to process *benefits*. When *we* receive a claim, *we* will notify *you* or the *provider* if any additional information is needed.

Submitting claim information and proof of loss
Either *you* or the *provider* must complete and submit to *us* all claim information for proof of loss. *We* would like to receive this information within 90 days after the *expense incurred date*; however, the claim will not be reduced or denied if it was not reasonably possible to meet the 90-day guideline. In any event, *we* will need written proof of loss notice within one *year* after the date proof of loss is requested, except if *you* were legally incapacitated.

Here are examples of information *we* may need (this is not a comprehensive list and only provides a few examples of the information *we* may request).

1. A complete dental chart showing:
   - Extractions;
   - Missing teeth;
   - Fillings;
   - Prosthesis;
   - Periodontal pocket depths;
   - Dates of previously performed work.
2. An itemized bill for all dental work.
3. The following exhibits:
   - X-rays;
   - Study models;
   - Laboratory and/or reports;
   - Patient records.
4. Authorizations to release any additional dental information or records.
5. Information about other insurance coverage.
6. Any information *we* need to determine *benefits.*

If *you* do not provide *us* with the necessary information, *we* will deny any related claims until *you* provide it to *us*.

Paying claims
We determine if *benefits* are available and pay promptly any amount due under this *policy* not more than 30 days after receipt of due written proof of loss. *We* may pay all or a portion of any *benefit* provided for *covered expenses* to the *provider* unless *you* have notified *us* in writing by the time the claim form is submitted. *Our* payments are made in good faith and will fully discharge *us* of any liability to the extent of such payment.

Reasons for denying a claim
Below is a list of the most common reasons for which *we* will not pay a claim. Claim payments may be limited or denied in accordance with any of the provisions contained in this *policy*.

1. **Not a covered benefit:** The *service* is not a *covered service* under this *policy*.
2. **Eligibility:** A *covered person* is no longer eligible under the "Terminating coverage" section of this *policy*, or the *expense incurred date* was prior to the *covered person's effective date*.
3. **Policy compliance:** The *covered person* has not acted in accordance with the *policy* requirements.
4. **Fraud:** *You* or a *covered person* make an intentional misrepresentation by not telling *us* the facts or withhold information necessary for *us* to administer coverage under this *policy.*

   Insurance fraud is a crime. Anyone who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains false or deceptive information may be guilty of insurance fraud.

   If *you* or a *covered person* commits fraud against *us*, as determined by *us*, *we* reserve the right to rescind coverage under this *policy* as of the date fraud is committed or as of the date otherwise determined by *us*. *We* will provide a 30-day advance written notice that coverage will be rescinded. A rescission is a retroactive cancellation or discontinuance of coverage. *We* will also provide information to the proper authorities and support any criminal charges which may

be brought. Further *we* reserve the right to seek any civil or remedies which may be available to *us*.

We will not end coverage if, after investigating the matter, *we* determine that the *covered person* provided information in error. *We* will adjust premium or claim payment based on this new information.

If correct information was provided and *we* made a processing error, the *covered person* will be eligible for coverage and claims payment for *covered expenses*. *We* will adjust *your* premium or claim payment based on the correct information.

5. **Duplicating provisions:** If any charge is described as covered under two or more *benefit* provisions, *we* will pay only under the provision allowing the greater *benefit*. This may require *us* to make a recalculation based on both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for *benefits* other than those this *policy* provides.

Legal actions
You or a *covered person* cannot bring a legal action to recover a claim until 60 days after the date written proof of loss is made. No action may be brought more than three *years* after proof of loss is made.

Claims paid incorrectly
If a claim was paid in error, *we* have the right to recover *our* payments, within 12 months from the date *we* paid the claim. *We* may correct this error by an adjustment to any amount applied to the *deductible* or *maximum benefits*. Errors may include such actions as:

1. Claims paid for *services* that are not actually covered under this *policy*.
2. Claims payment that is more than the amount allowed under this *policy*.
3. Claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of *our* payments made in error from anyone to, for or with respect to whom such payments were made; or any insurance companies or organizations that provide other coverage for the *covered expenses*. *We* will determine from whom *we* shall seek recovery. For information on *our* process, see the “Recovery rights” provision.

D. Other insurance coverage

If the *covered person* has insurance coverage with another insurer and did not inform *us* of this coverage on the application or such coverage is acquired after the *effective date* of this *policy*, *we* will only pay benefits for *covered expenses* that exceed the benefits payable under the other coverage. In no event will *our* payment be larger than the amount that would have been payable without this provision.

When a *covered person* is covered by more than one plan which provides dental benefits or *services*, benefits under this *policy* may be reduced so that the benefits and *services you* receive from all the other plans does not exceed 100 percent of the *covered expense*.

If the other coverage has a coordination of benefits provision and the amount of benefits is not determined according to the preceding provision, *we* will pay *covered expenses* at the proportionate amount. The proportionate amount means the ratio that the total amount of *covered expense* compared to the total amount of benefits payable under all other coverage, regardless of any limits imposed in other plans.

E. Excess coverage

We will not pay *benefits* for any *accidental injury* if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess or contingent. If *your* or the *covered person's* claim against another insurer is denied or partially paid, *we* will process the claim according to the terms and conditions of this *policy*. If *we* make a payment, *you* or the *covered person* agree to assign to *us* any right *you* or the *covered person* have against the other insurer for dental expenses *we* pay. Payments made by the other insurer will be credited toward any applicable *coinsurance* or *deductibles*.

F. Recovery rights

Your obligation in the recovery process
We have the right to collect *our* payments made in error. The covered person is obligated to cooperate and assist *us* and *our* agents to protect *our* recovery rights by:

1. Obtaining *our* consent before releasing any party from liability for payment of dental expenses.
2. Providing *us* with a copy of any legal notices arising from the *covered person's* injury and its treatment.
3. Assisting *our* enforcement of recovery rights and doing nothing to prejudice *our* recovery rights.
4. Refraining from designating all (or any disproportionate part) of any recovery as exclusively for "pain and suffering."

If the *covered person* fails to cooperate, *we* will collect from *you* any payments *we* made.

We will not request a refund or offset against a claim more than 12 months after *we* have paid a claim except in the case of fraud or misrepresentation by the health care provider.

Assignment of recovery rights
If the *covered person's* claim against the other insurer is denied or partially paid, *we* will process the claim according to the terms and conditions of this *policy*. If *we* make payment on the *covered person's* behalf, *you* and the *covered person* agree that any right for expenses the *covered person* has against the other insurer for expenses *we* pay will be assigned to *us*.

If *benefits* are paid under this *policy* and *you* or the *covered person* recover under any automobile, homeowners, premises or similar coverage, *we* have the right to recover from *you* or the *covered person* an amount equal to the amount *we* paid.

GENERAL PROVISIONS

G. Appeal rights

How to Challenge Our Claim Decision
If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* can request a second review of the claim, also known as an appeal. To request this review, the *covered person* must send *us* a letter requesting a second claim review within 60 days from the time *you* or the *covered person* received notice of *our* claim payment decision. The *covered person* may also send any information or documents that are relevant to *our* decision of how to pay the claim.

Once *we* receive the request, *we* will make a second review of the claim and provide notice of *our* decision following any processes or any timeframes required by state law.
.

Rights After a Second Claim Review and Denial
You or the *covered person* cannot bring any legal action against *us* prior to 60 days but not more than the time allowed by the applicable statute of limitations after the date all necessary claims payment information has been received. The *covered person* also must have completed a second claim review and utilized any external appeals procedure available under state law.

H. Assignment of benefits
Assignment of *benefits* may be made only with *our* consent. It is not binding until *we* receive and acknowledge in writing the original or copy of the assignment before payment of the *benefit*. *We* do not guarantee the legal validity or effect of such assignment.

I. Conformity with state statues
Any provisions that are in conflict with the laws of the states in which this *policy* is issued are amended to conform to the minimum requirements of those laws.

J. Cost of legal representation
The cost of *our* legal representation in matters related to *our* rights under this *policy* shall be borne solely by *us*. The costs of legal representation incurred by or on behalf of a *covered person* shall be borne solely by *you* or the *covered person*, unless *we* are given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

K. Entire contract

The rules governing *our* agreement to provide *you* with dental insurance in exchange for *your* premium payment are based on several written documents: this *policy*; riders, amendments, endorsements, and *your* application.

L. Modification of policy
This *policy* may be modified at any time by *us* without the consent of any *covered person*. Modifications will not be valid unless approved by *our* President, Vice President, Secretary or other authorized Officer. The approval must be endorsed on, or attached to, this *policy*. No agent has the authority to modify this *policy*, waive any of this *policy's*

provisions, extend the time for premium payment, make or alter any contract, or waive any of our Company's other rights or responsibilities.

M. Incontestability

After *you* have been insured for two *years*, *we* cannot contest the validity of coverage except for nonpayment of premium. Statements *you* or the *covered person* make cannot be contested unless they are in writing with *you* or the *covered person's* signature. A copy of the form must then be given to *you* or the *covered person*.

Every time *you* change coverage, either with or without an application, the two *year* review timeframe starts over with regard to the new information and *benefits*.

At any time, *we* may assert defenses based upon provisions in this *policy* which relate to *your* eligibility for coverage under this *policy*.

N. Relationship with providers

We and *providers* are at all times acting independently. *We* do not make any treatment decisions, nor prescribe treatment options, regardless of any coverage determinations *we* make under this *policy*.

O. Non-Insurance Discounts

Discount/access disclosure From time to time, *we* may offer or provide *covered persons* with access to discount programs. In addition, *we* may arrange for third-party dental service to provide *covered persons* with discounts on goods and *services*. Some of these third-party dental service providers may make payments to *us* when these discount programs are used. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration.

Who has responsibility for these discounts?
Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured *policy benefits*. The third-party providers are solely responsible for providing the goods and/ or *services*. *We* are not responsible for any goods and/ or *services* nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable for the negligent provision of such goods and/ or services by third-party service providers.
Discount programs may not be available to people who "opt out" of marketing communications, or where otherwise restricted by law.

P. Shared Savings

We have a Shared Savings Program that may provide *covered persons* with savings if *we* obtain discounts from *providers*. When *we* are able to obtain these discounts, the *covered person's deductible* and *coinsurance* will be calculated at the discounted amount.

The *covered person* does not need to inquire in advance about a *provider's* status. When processing the *covered person's* claim, *we* automatically will determine if the *provider* was participating in the program at the time treatment was provided, and *we* will

calculate the *covered person's deductible* and *coinsurance* on the discounted amount. The Explanation of Benefits statement will reflect any savings received.

However, the *covered person* may inquire in advance to determine if a *provider* participates in the Shared Savings Program by calling *us*. *Provider* arrangements in the Shared Savings Program change constantly. *We* cannot guarantee that a *provider* who is in the Shared Savings Program at the time of the *covered person's* inquiry will still be in the program at the time treatment is received. Discounts depend on availability on a claim by claim basis. Therefore, availability and discount amounts cannot be guaranteed.

We make no representations about the *providers* participating in the Shared Savings Program. Additionally, *we* reserve the right to modify, amend or discontinue the Shared Savings Program at any time.

DEFINITIONS

The following are definitions of terms used in this *policy*. Defined terms are printed in "*italic*" type wherever found in this *policy*.

Accidental injury: Damage to the mouth, teeth, and supporting tissue due directly to an accident. It does not include damage to the teeth, appliances or prosthetic devices that results from chewing or biting food or other substances.

Balance bill: The amount that a *non-network provider* may charge a *covered person*. Such amount equals the difference between the amount paid by *us* and the amount of the *non-network provider* charge.

Benefit: The amount payable for a *covered service* in accordance with the provisions of this *policy*.

Bodily injury: An injury due directly to an accident.

Coinsurance**:** Shared responsibility between the *covered person* and *us*. Our *coinsurance* is the percent of *covered expenses* payable as *benefits* after the deductible is satisfied, up to the maximum *benefit* if applicable, as shown in the "Adult Dental Benefit" and "Pediatric Dental Benefit" sections as applicable.

Clinical review**:** The review of required/submitted documentation by a *provider* for the determination of dental *services*.

Cosmetic dentistry: *Services* provided by a *provider* primarily for the purpose of improving appearance.

Covered expense: The *reimbursement limit* for a *covered service*.

Covered person: Anyone eligible to receive *policy benefits* as a *covered person*.

Covered service: A *service*:

1. Ordered by a *provider*;
2. For the *benefits* described herein, subject to any *maximum benefit*, and all other terms, provisions, limitations and exclusions of this *policy*; and
3. Incurred when a *covered person* is insured for that *benefit* under this *policy* on the *expense incurred date*.

Deductible: The amount of *covered expense* that a *covered person* must incur and is responsible to pay before *we* pay certain *benefits*.

Dental injury: An injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

Dependent:

1. *Your* legally recognized spouse;
2. *Your* unmarried natural child, step-child, foster child or legally adopted child whose age is less than the limiting age and who is not provided coverage as a named subscriber, insured, enrollee or *covered person* under any group or individual health

benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89097, 42 U.S.C. Section 1395, et seq.;

3. An unmarried child whose age is less than the limiting age and for whom *you* have received a court or administrative order to provide coverage and who is not provided coverage as a named subscriber, insured, enrollee or *covered person* under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89097, 42 U.S.C. Section 1395, et seq.;
4. *Your dependent* child who upon attainment of the limiting age while insured under this *policy* is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly *dependent* upon the *primary insured* for support and maintenance. Proof of such incapacity and dependency must be furnished to *us* by the *primary insured* at least 31 days after the child's attainment of the limiting age. *We* may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period *we* may require subsequent proof not more than once each year.

Dependent does not mean a:

1. Grandchild, unless such child is born to a *dependent* covered under this *policy*.
2. Great grandchild; or
3. Child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

The limiting age for each child to be considered a *dependent* under this *policy* is [no more than [25-31] years of age] [the *dependent*'s 31st birthday][the end of the month in which the *dependent* attains the age of 31].

A covered *dependent* child who becomes eligible for other dental coverage no longer is eligible for coverage under this *policy*.

We will not deny enrollment of a child on the grounds that: (1) the child was born out of wedlock; or (2) the child is not claimed as a *dependent* on the parent's federal income tax return; or (3) the child does not reside with the parent or in *our* service area.

Effective date: The first date all the terms and provision of this *policy* apply. It is the date that appears on the face page of this *policy* or on the date of any amendment, rider or endorsement hereto.

Emergency: A sudden, serious dental condition caused by an accident or dental disease that, if not treated immediately, would result in serious harm to the dental health of the *covered person.* Coverage for an *emergency* is limited to *palliative* care only.

Exchange: *A* governmental agency or nonprofit entity that meets the applicable standards and makes *qualified health plans* available to qualified individuals. An *exchange* refers to state exchanges, regional exchanges, subsidiary exchanges, a Federally-facilitated exchange, state partnership exchange, and state-based exchange.

Expense incurred: The amount *you* are charged for a *covered service*, subject to the *reimbursement limit*.

Expense incurred date: The date on which a *covered service* is performed.

DEFINITIONS

Family member: Anyone person related to the *covered person* by blood, marriage or adoption.

Geographic area: The three digit zip code in which the dental *service* is provided; or a greater area if necessary to obtain a representative cross-section of charges for a like dental *service*.

Identification card or ID: The card each *covered person* receives that contains *our* address and telephone number.

Maximum benefit: The maximum amount that may be payable for each *covered person* for *expenses incurred*. The applicable *maximum benefits* are shown in the "Adult Dental Benefit" section. No further *benefits* are payable once the *maximum benefits* are reached.

Negotiated fee: The rate mutually agreed upon between *us* and a *provider*.

Network provider: A *provider* under agreement with *us* to provide certain dental *services* to *covered persons* at contracted rates and terms.

Non-Network provider: A *provider* who is NOT under agreement with *us* to provide certain dental *services* to *covered persons* at contracted rates and terms.

***Open enrollment period*:** The period during which:

1. A *dependent* who did not enroll for coverage under this *policy* when first eligible or during a *special enrollment period* can enroll for coverage; or
2. A *covered person* has an opportunity to enroll in another health insurance plan.

If coverage was purchased through an *exchange,* the *exchange* will send prior notice of the *open enrollment period*. If coverage was not purchased through an *exchange*, visit our Website at [www.humana.com] for information on the *open enrollment period*.

Palliative: Treatment used in an *emergency* situation to relieve, ease or alleviate the acute severity of dental pain, swelling or bleeding. *Palliative* treatment usually is performed for, but not limited to, the following acute conditions:

1. Toothache;
2. Localized infection;
3. Muscular pain; or
4. Sensitivity and irritations of the soft tissue.

Services are not considered *palliative* when used in association with any other *covered services* except x-rays and/or exams.

Plan year: The period of time which begins immediately on *your effective date* and renews 12 months following the initial *effective date*. For persons enrolled other than on *your* initial *effective date* or a subsequent anniversary date, *benefits* begin immediately on the *covered person's* effective date and renew 12 months following the *covered person's* initial effective date.

Policy: The document describing the *benefits we* provide.

DEFINITIONS

Policyholder: The *primary insured*.

Primary insured: The person to whom this *policy* is issued. In the case of child-only coverage, *primary insured* is the parent or legal guardian in whose name coverage is issued.

***Provider*:** A medical professional who is professionally licensed by the appropriate state agency and who provides *services* within the scope of that license. A *provider's services* are not covered if the *provider* resides in the *covered person's* home or is a *family member*.

***Qualified health plan*:** A health plan that is certified and meets the standards issued or recognized by each *exchange* through which the plan is offered.

***Reimbursement limit*:** The maximum fee allowed for *covered services.* It is the lesser of:

1. The actual cost for *covered services*;
2. The fee most often charged in the geographical area where the *service* was performed;
3. The fee most often charged by the *provider*;
4. The fee determined by comparing charges for similar *services* to a national database adjusted to the geographical area where the *services* or procedures were performed;
5. At *our* choice the fee determined by using a national Relative Value Scale. Relative Value Scale means a methodology that values procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed;
6. In the case of *services* rendered by *providers* with whom *we* have agreements, the fee that *we* have negotiated with that *provider*;
7. The fee based on rates negotiated with one or more *network providers* in the geographic area for the same or similar *services*;
8. The fee based on the *provider's* costs for providing the same or similar *services* as reported by the *provider* in the most recent, publicly available *Medicare* cost report submitted annually to the Centers for Medicare and Medicaid Services; or
9. The fee based on a percentage of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

The bill a *covered person* receives for *services* provided by *non-network providers* may be significantly higher than the *reimbursement limit*. In addition to any applicable *deductible* and *coinsurance*, a *covered person* is responsible for the difference between the *reimbursement limit* and the amount the *provider* bills *you* or the *covered person* for the *services*. Any amount paid to the *provider* in excess of the *reimbursement limit* will not apply to any applicable *deductible* or out-of-pocket maximum.

Renewal: The time frame established by billing mode for premium payment.

Services: Procedures, surgeries, examinations, consultations, advice, diagnosis, referrals, tests unless otherwise limited or excluded in this *policy*, treatment, supplies, drugs, devices or technologies.

DEFINITIONS

Sickness: A disturbance in function or structure of the *covered person's* body which causes physical signs or symptoms that, if left untreated, will result in a deterioration of the covered person's health state of the structure of system(s) of the *covered person's* body.

Sound natural tooth: A tooth that:

1. Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Special enrollment period**:** A 60 day period of time during which a *covered person* or dependent who has a qualifying event may enroll for coverage outside of an *open enrollment period.*

Treatment plan: A written report on a form satisfactory to *us*, which is completed by the *provider*. It consists of:

1. A list of the *services* to be performed, using the American Dental Association Nomenclature and codes;
2. The *provider's* written description of the proposed treatment;
3. Supporting pretreatment x-rays showing the *covered person's* dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials as requested by *us*.

We, us and our: The insurer as shown on the cover page of this *policy*.

Year, Yearly: The *plan year*.

You and your: The *primary insured.*

Humana Insurance Company
1100 Employers Blvd.
Green Bay, WI 54344

INDIVIDUAL DENTAL POLICY – TN HUMD IND 2014
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY! This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

DENTAL POLICY
Policies of this category are designed to provide, to *covered persons*, benefits for covered dental expenses incurred up to the maximum amount shown in the schedule of benefits. A covered charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

Schedule

Deductible	$100 *Network Provider* / $100 *Out of Network Provider*
Annual Maximum	$1,000 per *covered person* under the "Adult Dental Benefit" section

Your Benefit Percentage	**In-Network Services**	**Out-of-Network Services**
Class I Services		
Oral Evaluations (includes Routine and Periodontal evaluations); 2 every *year*	100 % (*deductible* waived)	70 % after *deductible*
Cleaning [Prophylaxis]; 2 per *year*	100 % (*deductible* waived)	70 % after *deductible*
Fluoride; 2 every *year*, 14 years and younger	100 %(*deductible* waived)	70 % after *deductible*
Sealants; 14 years and younger, 1 per tooth per lifetime, allowed on occlusal surface of permanent molars free of decay and restorations	100 %(*deductible* waived)	70 % after *deductible*
Removal of fixed space maintainer; 1 per lifetime; children under age 19	100 % (*deductible* waived)	70 % after *deductible*
Miscellaneous X-rays: only to diagnose specific treatment.	100 % (*deductible* waived)	70 % after *deductible*
Space Maintainers Children under age 19	100 % (*deductible waived)*	70 % after *deductible*
Bitewing X-rays; 1 sets per *year*	100 % (*deductible* waived)	70 % after *deductible*
Full Mouth/Panoramic X-rays; 1 every 5 *years* to age 19.	100 % (*deductible* waived)	70 % after *deductible*
Class II Services		
***Palliative* Treatment;** Allowed if no other *services* than x-rays on claim	50 % after *deductible*	50 % after *deductible*
Fillings (Amalgams/Composites); 1 per tooth every 2 *years*, Composites allowed on anterior teeth only, alternate *benefit* for amalgam allowed on posterior teeth.	50 % after *deductible*	50 % after *deductible*
Stainless Steel Crowns	50 % after *deductible*	50 % after *deductible*
Surgical Extractions	50 % after *deductible*	50 % after *deductible*
Oral Surgery	50 % after *deductible*	50 % after *deductible*
Extractions; Extractions and root removals (non-	50 % after *deductible*	50 % after *deductible*

surgical)

Class III Services

Recementation (Crowns, Bridges, Inlays & Onlays) Children under age 19	50 % after *deductible*	50 % after *deductible*
Endodontic, Periodontal and Prosthodontic Services Children under age 19	50 % after *deductible*	50% after *deductible*
Implant Services Children under age 19	50% after *deductible*	50% after *deductible*
Inlays/Onlays, Veneers, Post & Core Build-Up, Maintenance - Children under age 19	50 % after *deductible*	50% after *deductible*

Class IV Services

Orthodontic Services Children under age 19	50% after *deductible*	50% after *deductible*

PPO

You have the freedom to choose the *provider* of *your* choice. However, *you* will receive *maximum benefits* by seeing a *network provider*. If *you* visit a *non-network provider*, *you* may be *balance billed* for any *expense incurred* that exceeds *our reimbursement limit*.

If *you* are traveling or need *emergency* care and are unable to access care from a *network provider*, *benefits* will be paid at the *non-network* level.

How your plan works

General benefit payments

We pay *benefits* for *covered expenses,* as stated in the Schedules found in the "Adult Dental Benefit" and "Pediatric Dental Benefit" sections, and according to any riders that are part of this *policy.* All *benefits we* pay are subject to all conditions, limitations, exclusions and maximums of this *policy*.

Deductibles

The *deductible* is the amount shown on the Schedules that the *covered person* must pay in *covered expenses* before *we* pay any *coinsurance*.

Coinsurance

Coinsurance is shared responsibility between the *covered person* and *us*. The level of *coinsurance* of *covered expenses we* will pay toward the total *expenses incurred* for *services* is shown on the Schedules.

Waiting periods

This is the time period that certain *services* are not eligible for coverage under this *policy*. This begins on a *covered person's effective date* and lasts for the time shown in the Schedules.

Benefit maximums

The amount *we* pay for *services* under the "Adult Dental Benefit" section is limited to a *maximum benefit*. *We* will not make *benefit* payments that are more than the *maximum benefit* for the *covered services* shown in the Schedules.

Pretreatment Plan

How can *you* find out what will be covered before *you* receive treatment?

If dental treatment is expected to exceed $300, *you* or *your provider* can submit a dental *treatment plan* to *us* for review prior to treatment. The dental *treatment plan* should consist of:

1. A list of the *services* to be performed, using the American Dental Association Nomenclature and codes:
2. *Your provider's* written description of the proposed treatment;
3. Supporting pretreatment x-rays showing *your* dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials as requested by *us*.

Limitations & exclusions (all services)

In addition to the limitations and exclusions listed in the "Pediatric Dental Benefit" section, this *policy* does not provide *benefits* for the following:

1. Any *expenses incurred* while a *covered person* qualifies for any worker's compensation or occupational disease act or law, whether or not the *covered person* applied for coverage.
2. *Services*:
   A. That are free or that a *covered person* would not be required to pay for if they did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   B. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   C. Furnished by any U.S. government-owned or operated hospital/institution/agency for any *service* connected with *sickness* or *bodily injury.*
3. Any loss caused or contributed by:
   A. War or any act of war, whether declared or not;
   B. Any act of international armed conflict; or
   C. Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Failure to keep an appointment with the *provider*.
6. Any *service we* consider *cosmetic dentistry* unless it is required as a result of an *accidental injury* sustained while the *covered person* is covered under this *policy*. *We* consider the following *cosmetic dentistry* procedures:
   A. Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid.
   B. Any *service* to correct congenital malformation;
   C. Any *service* performed primarily to improve appearance; or
   D. Characterizations and personalization of prosthetic devices.
7. Charges for:
   A. Precision or semi-precision attachments;
   B. Overdentures and any endodontic treatment associated with overdentures; or
   C. Other customized attachments.
8. Any *service* related to:
   A. Altering vertical dimension of teeth;
   B. Restoration or maintenance of occlusion;
   C. Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   D. Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   E. Bite registration or bite analysis.
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical or treatment facility, or for *services* of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any *service* not specifically listed in "Adult Dental Benefits" and "Pediatric Dental Benefits" section, as applicable. .
14. Any *service* that *we* determine:
    A. Is not a *dental necessity*;
    B. Does not offer a favorable prognosis;
    C. Does not have uniform professional endorsement; or
    D. Is deemed to be experimental or investigational in nature.
15. Orthodontic *service*s unless otherwise stated in this *policy*.

16. Any *expense incurred* before the *covered person's effective date* or after the date the *covered person's* coverage under this *policy* terminates.
17. *Services* provided by someone who ordinarily lives in the *covered person's* home or who is a *family member.*
18. Charges exceeding the *reimbursement limit* for the *service*.
19. Treatment resulting from any intentionally self-inflicted injury or *bodily illness*.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental *services*, study models, *treatment plans*, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service.*
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull unless otherwise stated in this *policy*; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Elective removal of non-pathologic impacted teeth.
24. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
25. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
26. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.

Changes to Your Premium

Premium may change when:

- Family members are added or deleted;
- Coverage is increased or decreased;
- A *covered person* moves to a different zip code or county;
- Premium payment method is changed;
- A new rate table applies;
- Any *covered person's* age increases;
- Any *covered person's* rating classification changes; or
- A misstatement on the application form results in the proper amount due not being charged.

We will notify *you* of any premium change. *Your* continued payment of premium will stand as proof of *your* agreement to the change.

Terminations

Terminating coverage

Your insurance coverage may end at any time, as stated below. Coverage terminates on the earliest of the following events:

1. Failure to pay premium by the required due date;
2. The end of the month *you* enter the military fulltime;
3. The end of the month *you* or a *covered person* are covered on a group plan;
4. The date a *covered person* commits fraud or intentional misrepresentation of a material fact, as determined by *us*;
5. For a *dependent*, the end of the month *your* insurance terminates;
6. For a *dependent,* the end of the month he/she no longer meets the definition of a *dependent*;
7. The end of the month following *your* request that insurance be terminated for *you* and/or *your dependents* given that coverage has been continuously in force for at least 12 months from the *effective date* of this *policy*, unless *you* are eligible for a *special enrollment period*;
8. The end of the month *you* enroll in another dental insurance plan during an *open enrollment period*;
9. The end of the month that a change in *your* legal residence from the state in which this *policy* was issued occurs;
10. The end of the month *you* move outside the service area, as determined by *us*. Call the telephone number on *your ID card* for this *policy's* service area; or
11. If coverage was purchased through an *exchange*:
    a. *You* cease to be eligible for coverage through an *exchange*; or
    b. This *policy* ceases to be a *qualified health plan* and is decertified by an *exchange*.

    If coverage was purchased through an *exchange*, the *exchange* will initiate the termination and notify *us* of the event. The termination date will be assigned.

If coverage under this *policy* is terminated due to fraud or an intentional misrepresentation of a material fact, a 30-day advance written notice of the termination will be provided.

INDIVIDUAL DENTAL POLICY
HUMANA INSURANCE COMPANY

[For Claims Information]
[PO Box 14635]
[Lexington, KY 40512-4635]
[Toll-Free 1-800-833-6917]

[For All Other Inquiries]
[PO Box 30111]
[Tampa, FL 33630-3111]
[Toll-Free 1-800-458-1354]

[*Policyholder name:*]	[John Doe]
[*Policy* number]	[12345]
Effective date:	[January 1, 2014 as of 12:01 a.m.]
[Initial] premium amount:	[$ Monthly/Quarterly/Semi-annually/Annually]

Humana Insurance Company agrees to pay *benefits* for *services* rendered to *covered persons*, subject to all the terms and provisions of this *policy*. *We* reserve the full and exclusive right to interpret the terms of this *policy* and to determine the *benefits* payable thereunder.

Important Notice

***Your* coverage under this *policy* is issued in consideration of *your* payment of premiums as provided herein.**

This *policy* and the insurance it provides become effective 12:01a.m. (*your* time) of the *effective date* stated above. This *policy* and the insurance it provides, terminates at 12:00 midnight (*your* time) of the date of termination. The provisions stated above and on the following pages are part of this *policy*.

Notice to Buyer

This *policy* provides coverage for limited dental *services*. If *you* have any questions regarding *your* coverage, or if *you* need assistance in resolving a complaint, contact *us.*

Right to Return Policy

You have the right to return this *policy* within 10 calendar days of its initial delivery. If *you* choose to return this *policy* within the 10 day period, *we* will refund any premium that *you* have paid. If *you* return this *policy* within the 10 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *policy*. There will be no coverage for any claims incurred.

Renewability

Coverage remains in effect at *your* option except as provided in the “Termination Rights” section of this *policy*.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

ELIGIBILITY

Dependent coverage

Eligibility date: If the *primary insured* is covered, the *primary insured's dependent* is eligible for coverage:

1. On the date the *primary insured* is eligible for coverage; or
2. On the date a *special enrollment period* applies.

Adding dependents
If a child is born to a *policyholder*, or any *covered person*, a *policyholder* adopts a child, or a child is placed with the *policyholder* for the purpose of adoption *we* must be notified of the event in writing and receive any required premium within 31 days (60 days if coverage was purchased through an *exchange*) of the event.

If *we* do not receive notice and premium for the first 31 days (60 days if coverage was purchased through an *exchange*) and forward the child must wait to enroll for coverage during the next *open enrollment period*, unless such child becomes eligible for a special enrollment as specified in the "Special Enrollment" provision.

For a *dependent* not falling under the previous paragraphs the *dependent* must wait to enroll for coverage during the next *open enrollment period*, unless the *dependent* becomes eligible for a special enrollment as specified in the "Special Enrollment" provision.

Upon *our* receipt of the [completed application and] premium, an *effective date* will be assigned. A *dependent* child is eligible to apply if they are under age [26 – 31].

Effective date of dependent changes

a. Coverage for a newborn or adopted child will be effective on the date of birth, placement or adoption, provided *you* remit the premium within 31 days (60 days if coverage was purchased through an *exchange*) of the child's date of birth or adoption.
b. If *we* receive any required premium more than 31 days (60 days if coverage was purchased through an *exchange*) after the newborn's date of birth or the child's adoption or placement for adoption, such child will be covered on the effective date assigned.

For changes for other *dependents* an effective date will be assigned upon *our* receipt of a completed application and any required premium.

Application: If *you* have any questions in regard to applying, for *dependent* coverage, please contact *us.*

A *dependent's* effective date cannot occur before the *insured's effective date* of coverage.

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Rate Information

Rate data applies to filing.

Filing Method:	File and Approve
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	N/A

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Humana Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual	TN HUMD IND 2014	New		TN Smart Choice Rate Manual.xlsm,

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Attachment TN Smart Choice Rate Manual.xlsm is not a PDF document and cannot be reproduced here.

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter Accident & Health
Comments:	
Attachment(s):	2014 filing letter.pdf
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Description of Variables
Comments:	
Attachment(s):	Statement of Variability.pdf
Item Status:	Approved
Status Date:	07/30/2013

Bypassed - Item:	Filing Fees
Bypass Reason:	Wisconsin, our domicile state, does not have a filing fee.
Attachment(s):	
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Signed readability certificate.pdf
Item Status:	Approved
Status Date:	07/30/2013

Bypassed - Item:	Third Party Authorization
Bypass Reason:	Not a third party filer.
Attachment(s):	

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Actuarial Memorandum A & H Certification - Individual
Comments:	Please see the attached Actuarial Memorandum as well as the required A&H Certification.
Attachment(s):	TN Actuarial Certification.pdf TN Smart Choice Actuarial Memorandum.pdf
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Accident & Health - Individual New Rates
Comments:	Please see the attached Rate Manual. The Actuarial Memorandum is within the requirement titled 'Actuarial Memorandum A & H Certification - Individual'.
Attachment(s):	TN Smart Choice Rate Manual.xlsm
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Response letter
Comments:	
Attachment(s):	Response letter 7.10.13.pdf
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Claims Trend Graph
Comments:	Please see the attached exhibit.
Attachment(s):	Claims Trend Graph.pdf
Item Status:	Approved
Status Date:	07/30/2013

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Satisfied - Item:	Tennessee Rating Areas
Comments:	Please see the attached file which defines the rating areas for both Tennessee and Humana by county.
Attachment(s):	Tennessee Rating Areas.xlsx
Item Status:	Approved
Status Date:	07/30/2013

Satisfied - Item:	Response letter 7.30.13
Comments:	
Attachment(s):	Response letter.pdf
Item Status:	Approved
Status Date:	07/30/2013

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Attachment TN Smart Choice Rate Manual.xlsm is not a PDF document and cannot be reproduced here.

Attachment Tennessee Rating Areas.xlsx is not a PDF document and cannot be reproduced here.

June 3, 2013

Julie Mix-McPeak, Commissioner
Tennessee Department of Commerce and Insurance
Davy Crockett Tower, 5th Floor
500 James Robertson Parkway
Nashville, TN 37243

RE: INDIVIDUAL DENTAL INSURANCE FORMS FILING
HUMANA INSURANCE COMPANY
NAIC #119-73288

Form number	**Description**
TN HUMD IND 2014	Policy cover
HUMD IND TOC 2014	Table of Contents
HUMD IND PPO 2014	PPO Provision
TN HUMD IND ABEN 2014	Adult Dental Plan Benefits
HUMD IND PED BEN 2014	Pediatric Dental Plan Benefits
HUMD IND L&E 2014	Limitations and Exclusions
HUMD IND ELIG 2014	Eligibility
HUMD IND CHG 2014	Changes to coverage
TN HUMD IND PREM 2014	Premium payment
HUMD IND TER 2014	Termination
TN HUMD IND GP 2014	General Provisions
HUMD IND DEF 2014	Definitions
TN-HUMD-IND-OC-2014	Outline of Coverage

Dear Commissioner McPeak:

We respectfully submit for your approval the attached forms. This is a new filing; the attached forms do not replace or supersede any like forms previously filed.
The forms included in this filing are intended for use with new individual dental plans on and off exchange.

These form(s) support the current 2014 ACA Federal requirements and business initiatives.

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Tennessee statutes and regulations.

Upon approval, please notify via SERFF. If you have any questions regarding this filing, please contact me by phone at (502) 580-4230, or via SERFF.

Sincerely,
HUMANA INSURANCE COMPANY

Nancy E. Anderson
Compliance Consultant

Statement of Variability

- All demographic information remains variable text. This information does not impact the benefits of the product, but is merely used as a form of identification in the course of product administration.

- All bracketed numbers are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

- Bracketed text within the policy may be moved or omitted.

- Product information, including items which customarily vary according to the policyholder's specific plan of insurance is bracketed to allow for the product design chosen.

- The signature, typed name, and title of the Company Officer are bracketed in the event of a change in leadership within the Company.

- Web address is bracketed in the event it changes.

- We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting to your department, and to amend the language to clarify the intent within the confines of the law.

Department of Insurance
State of Arizona
Life and Health Division
Telephone: (602) 364-2393
Facsimile: (602) 364-2175

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

GERMAINE L. MARKS
Director of Insurance

READABILITY CERTIFICATION

Arizona Administrative Code R20-6-213
Life and Disability Insurance Policy Language Simplification

COMPANY NAME Humana Insurance Company, NAIC # 119-73288, hereby certifies that the following form(s) comply with the requirements of paragraph (C)(1)(a) of the captioned Rule and achieve a Flesch reading ease test score of:

FORM NUMBER	FLESCH SCORE
HUMD IND 2014 - entire policy	48.7

Bruce Broussard

Signature of Insurance Company Officer
(rubber stamp, copy or facsimile NOT ACCEPTED)

Bruce Broussard, President

Typed Name and Title

March 29, 2013

Date

Certification is required for all policy forms. A photocopy of this specimen is acceptable.

0780-1-20-.02 ACTUARIAL MEMORANDUM.

Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called ‘‘anticipated loss ratio,’’ of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary.

Please have the actuary preparing this document sign the certification below. This must be an actual signature, not computer generated or rubber stamped.

I certify that to the best of my knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

Signature 

Print name Steven J Laabs FSA, MAAA

Title Managing Actuary, Humana Insurance Company

HUMANA INSURANCE COMPANY
Actuarial Memorandum

Dental Policy Form TN HUMD IND 2014

1. **Scope and Purpose** – The purpose of this actuarial memorandum is to describe the benefits and assumptions for the Individual Dental Policy Form TN HUMD IND 2014

2. **Benefits Description and Actuarial Value** – This Form provides benefits for covered Dental services. This plan intends to comply with ACA regulations set forth governing pediatric dental essential health benefits as well as Tennessee specific regulations.

Children (Ages 0-19) - Benefits may vary depending on whether or not a participating dentist is used and may be subject to coinsurance, a deductible, and a maximum out of pocket limit. The services covered include Diagnostic, Preventive, Oral Surgery, Restorations, Extractions, Recementations, Periodontics, Endodontics, Prosthodontics, Implants, and Medically Necessary Orthodontics. Please see the policy for more details on the specific benefits.

Adults (Ages 20+) - Benefits may be subject to coinsurance, may vary depending on whether or not a participating dentist is used, and may be subject to either a deductible or annual maximum or both. The services covered include Diagnostic, Preventive, Oral Surgery, Restorations, Extractions, and Recementations. Additionally, discounts on Periodontic Services, Endodontic Services, Prosthodontic Services, Implants, and Orthodontic Services may be provided when a participating dentist is used. Please see the policy for more details on the specific benefits.

This plan carries an Actuarial Value within the de minimis range for a Low Actuarial Value stand-alone dental plan (70% +/- 2%).

3. **Renewability Clause** – This Form is Guaranteed Renewable for life at the premium rate effective on the renewal anniversary date.

4. **Applicability** – This filing is for the Individual Dental Policy Form TN HUMD IND 2014. The rates will apply to newly issued policies sold on the Exchange.

5. **Morbidity** – Child rates were developed by utilizing proprietary company experience from group products with broad coverage similar to that offered in this plan. This experience was adjusted for benefit differences, differences in utilization rates between group members and individual members, and adjusted to reflect rating methodology differences. Proprietary consultant data was used where experience was not credible to develop appropriate claim cost expectations.

Adult rates were developed by utilizing proprietary company experience from other individual products and adjusted for benefit differences. Proprietary consultant data was used where experience was not credible to develop appropriate claim cost expectations.

6. **Mortality** – Mortality is not a significant factor in the pricing; however, the impact of mortality is reflected in the persistency rates.

7. **Persistency** – The persistency rates assumed in pricing are based on Company experience and are as follows:

Duration	Persistency
1	54%
2	58%
3+	64%

8. **Expenses** – The expense assumptions are based on the Company's incurred costs. These expenses cover general administrative, commissions, commission bonuses, premium taxes, and Exchange fees.

Anticipated Loss Ratio	56.2%
General Expenses	16.2%
Acquisition Cost*	6.1%
Premium Tax**	4.4%
Exchange Fee	3.5%
Provision for Tax	4.7%
Provision for Profit and Contingencies	8.9%
Total	100.0%

*Acquisition Cost includes commissions, commission bonuses, and direct to consumer marketing expenses.
**The state premium tax for TN accounts for 2.0% and the federal healthcare reform premium tax accounts for 2.4%.

9. **Marketing Method** – This Form will be distributed through brokers, sales agents and directly to consumers through the internet, direct mail, e-mail, print advertising and other forms of communication. This Form will only be available to members through the Exchange.

10. **Underwriting** – This Form is guaranteed issue and not underwritten based on health status.

11. **Premium Classes** – Rates will vary based on rating area, effective date, the age of each insured member on a policy, and the number of members on a policy limited to adults and no more than 3 dependent children. The premium algorithm is shown in the associated Rate Manual.

12. **Issue Age Range and Age Factors** – There are no restrictions on issue age. Age factors capture utilization differences observed on a similar product and are supplemented with consultant data. The age factors are displayed in the associated Rate Manual.

13. **Area Factors** – The premium rates for this form will vary by rating area. Area factors capture utilization and unit cost differences observed on a similar product and are supplemented with consultant data. The area factors are displayed in the associated Rate Manual.

14. **Trend Factor** – The premium rates for this form will vary by trend factor. The trend factors are displayed in the associated Rate Manual.

15. **Average Annual Premium** – The anticipated average annual premiums per policy for this Form are $380.

16. **Premium Modalization Rules** – This Form will be primarily billed monthly. Quarterly rates will be three times monthly rates, semi-annual rates will be six times monthly rates and annual rates will be twelve times monthly rates.

Please see the associated Rate Manual for additional premium information.

17. **Claim Liability and Reserves** – The IBNR claim reserves will be set based on a claim lag basis. A check against historical claim PMPMs and paid claims for the first lag month will also be made to assure there is no major shift from historical experience. Claim reserves will use an anticipated loss ratio method until relevant experience is available to complete reserves based on a claim lag basis.

18. **Active Life Reserves** – Statutory active life reserves will be gross unearned premiums.

19. **Trend Assumption** – Annual trend is expected to be up to 10% per year.

20. **Contingency and Risk Margins** – The risk margin for this Form is sufficient to meet the minimum return on the Company's Risk-based Capital requirements.

21. **Experience** – This is a new form with no experience.

22. **Lifetime Loss Ratio** – The anticipated lifetime loss ratio exceeds 55%.

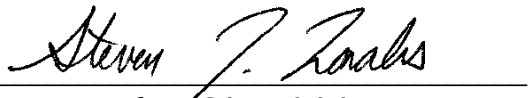
23. **History of Rate Adjustments** – This is a new form.

24. **Number of Policyholders** – This is a new form.

25. **Proposed Effective Date** – January 1st, 2014.

26. **Actuarial Certification** – I, Steven J. Laabs, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify that to the best of my knowledge and judgment:

(i) this entire rate filing is in compliance with the applicable laws of the state and with the rules of the Department of Insurance;
(ii) complies with applicable Actuarial Standards of Practice; and
(iii) that the benefits provided by this Form are reasonable in relation to the proposed premiums, which are neither excessive, inadequate, nor unfairly discriminatory.



July 22, 2013

Steven J. Laabs, FSA, MAAA
Managing Actuary
Humana Insurance Company

Date

July 10, 2013

Melissa Merritt
Tennessee Department of Commerce and Insurance
Davy Crockett Tower, 5th Floor
500 James Robertson Parkway
Nashville, TN 37243

RE: INDIVIDUAL DENTAL INSURANCE FORMS FILING
HUMANA INSURANCE COMPANY
NAIC #119-73288

Form number	**Description**
TN HUMD IND 2014	Policy cover
HUMD IND TOC 2014	Table of Contents
HUMD IND PPO 2014	PPO Provision
TN HUMD IND ABEN 2014	Adult Dental Plan Benefits
HUMD IND PED BEN 2014	Pediatric Dental Plan Benefits
HUMD IND L&E 2014	Limitations and Exclusions
TN HUMD IND ELIG 2014	Eligibility
HUMD IND CHG 2014	Changes to coverage
TN HUMD IND PREM 2014	Premium payment
HUMD IND TER 2014	Termination
TN HUMD IND GP 2014	General Provisions
HUMD IND DEF 2014	Definitions
TN-HUMD-IND-OC-2014	Outline of Coverage

Dear Ms. Merritt:

Thank you for your review of the captioned forms.

We have removed the brackets from the face page and from the Eligibility section where we had proposed to include or omit language based on whether the policy was to be sold on the exchange or off. This form will only be used on the exchange, so we have deleted all references to the application.

Regarding the Orthodontic benefit, the Q and A from CMS left the definition of Medically Necessary Orthodontia up to the discretion of the carrier. Our policy's Orthodontia benefit reflects our definition of "medically necessary orthodontia."

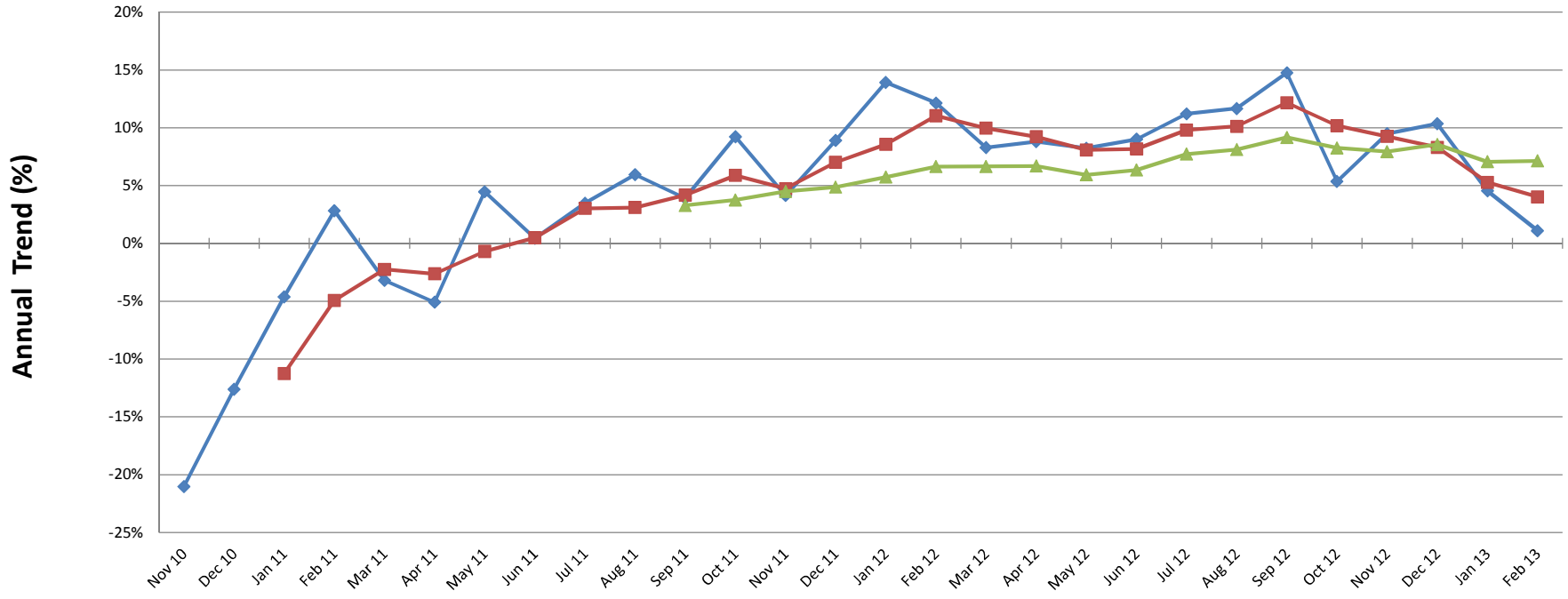
> **Q12: What is the definition of medically-necessary orthodontia?**
> A12: Issuers will be responsible for developing standards to define medically-necessary orthodontia.

Sincerely,
HUMANA INSURANCE COMPANY

Nancy E. Anderson

Compliance Consultant

Observed Claims Trend



	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13
1 Mo Annual Trend	-21%	-13%	-5%	3%	-3%	-5%	4%	0%	3%	6%	4%	9%	4%	9%	14%	12%	8%	9%	8%	9%	11%	12%	15%	5%	10%	10%	5%	1%
3 Mo Annual Trend			-11%	-5%	-2%	-3%	-1%	0%	3%	3%	4%	6%	5%	7%	9%	11%	10%	9%	8%	8%	10%	10%	12%	10%	9%	8%	5%	4%
12 Mo Annual Trend											3%	4%	5%	5%	6%	7%	7%	7%	6%	6%	8%	8%	9%	8%	8%	9%	7%	7%

July 30, 2013

Ms. Victoria Stotzer
Tennessee Department of Commerce and Insurance
Davy Crockett Tower, 5th Floor
500 James Robertson Parkway
Nashville, TN 37243

RE: INDIVIDUAL DENTAL INSURANCE FORMS FILING
HUMANA INSURANCE COMPANY
NAIC #119-73288
SERFF # HUMA-128968624

Form number	**Description**
TN HUMD IND 2014	Policy cover
HUMD IND TOC 2014	Table of Contents
HUMD IND PPO 2014	PPO Provision
TN HUMD IND ABEN 2014	Adult Dental Plan Benefits
TN HUMD IND PED BEN 2014	Pediatric Dental Plan Benefits
HUMD IND L&E 2014	Limitations and Exclusions
HUMD IND ELIG 2014	Eligibility
HUMD IND CHG 2014	Changes to coverage
TN HUMD IND PREM 2014	Premium payment
HUMD IND TER 2014	Termination
TN HUMD IND GP 2014	General Provisions
HUMD IND DEF 2014	Definitions
TN-HUMD-IND-OC-2014	Outline of Coverage

Dear Ms. Stotzer:

Thank you for your review of the captioned forms, and for your e-mail regarding the Pediatric Dental Benefit.

We have removed the lifetime limits from the orthodontia benefit and removed the requirement of certain conditions for orthodontic treatment.

In addition, we have changed several of the benefits to comply with CMS requirements: Bitewing X-rays, Immediate dentures, extractions, pulpotomy, periodontal and osseous surgery, periradicular procedures, root canal therapy and treatment and sealants.

We appreciate your time and attention to this filing. If you have any questions or need additional information please feel free to contact me.

Sincerely,

Nancy E. Anderson
Humana
500 W. Main Street
Louisville, KY 40202
(502) 580-4230
nanderson1@humana.com

SERFF Tracking #:	*HUMA-128968624*	***State Tracking #:***	*H-130807*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Humana Insurance Company*
TOI/Sub-TOI:	*H10I Individual Health - Dental/H10I.000 Health - Dental*		
Product Name:	*Individual Dental Insurance*		
Project Name/Number:	*Stand-alone Dental/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/23/2013	Replaced 07/30/2013	Rate	Rate Manual	07/26/2013	TN Smart Choice Rate Manual.xlsm (Superceded)
04/09/2013	Replaced 07/30/2013	Form	Policy Cover	07/10/2013	TN HUMD IND 2014.pdf (Superceded)
04/09/2013	Replaced 07/30/2013	Form	Pediatric Dental Benefit	07/30/2013	HUMD IND PED BEN 2014.pdf (Superceded)
04/02/2013	Replaced 07/30/2013	Supporting Document	Actuarial Memorandum A & H Certification - Individual	07/23/2013	TN Smart Choice Actuarial Memorandum.pdf (Superceded) TN Actuarial Certification.pdf

SERFF Tracking #:	HUMA-128968624	**State Tracking #:**	H-130807	**Company Tracking #:**

State:	Tennessee	**Filing Company:**	Humana Insurance Company
TOI/Sub-TOI:	H10I Individual Health - Dental/H10I.000 Health - Dental		
Product Name:	Individual Dental Insurance		
Project Name/Number:	Stand-alone Dental/		

Attachment TN Smart Choice Rate Manual.xlsm is not a PDF document and cannot be reproduced here.

INDIVIDUAL DENTAL POLICY
HUMANA INSURANCE COMPANY

[For Claims Information]
[PO Box 14635]
[Lexington, KY 40512-4635]
[Toll-Free 1-800-833-6917]

[For All Other Inquiries]
[PO Box 30111]
[Tampa, FL 33630-3111]
[Toll-Free 1-800-458-1354]

[*Policyholder name:*]	[John Doe]
[*Policy* number]	[12345]
Effective date:	[January 1, 2014 as of 12:01 a.m.]
[Initial] premium amount:	[$ Monthly/Quarterly/Semi-annually/Annually]

Humana Insurance Company agrees to pay *benefits* for *services* rendered to *covered persons*, subject to all the terms and provisions of this *policy*. *We* reserve the full and exclusive right to interpret the terms of this *policy* and to determine the *benefits* payable thereunder.

Important Notice

[Please read the copy of *your* application. Carefully check for errors and report any errors in the information provided in *your* application to *us*.] *Your* coverage under this *policy* is issued in consideration of *your* [application;] [a copy of which is attached and made part of this *policy*,] [and *your*] payment of premiums as provided herein. [An incorrect or incomplete application may cause a *covered person's* coverage to be voided and claims to be reduced or denied.]

This *policy* and the insurance it provides become effective 12:01a.m. (*your* time) of the *effective date* stated above. This *policy* and the insurance it provides, terminates at 12:00 midnight (*your* time) of the date of termination. The provisions stated above and on the following pages are part of this *policy*.

Notice to Buyer

This *policy* provides coverage for limited dental *services*. If *you* have any questions regarding *your* coverage, or if *you* need assistance in resolving a complaint, contact *us.*

Right to Return Policy

You have the right to return this *policy* within 10 calendar days of its initial delivery. If *you* choose to return this *policy* within the 10 day period, *we* will refund any premium that *you* have paid. If *you* return this *policy* within the 10 day period, it will be void and *we* will have no liability under any of the terms or provisions of this *policy*. There will be no coverage for any claims incurred.

Renewability

Coverage remains in effect at *your* option except as provided in the "Termination Rights" section of this *policy*.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

PEDIATRIC DENTAL BENEFIT

This Pediatric Dental Benefits section describes the dental *benefits* that will be considered *covered expenses* for *covered persons* under the age of 19. There are no Pediatric Dental *Benefits* available for *covered persons* age 19 or older. In the event of any conflict between this Pediatric Dental Benefits section and other provisions contained in this *policy*, the provisions of this Pediatric Dental Benefits section shall control.

Notwithstanding any other provisions of this *policy*, *covered expenses* under this section are not covered under any other provision of this *policy*. Any amount in excess of the maximum amount provided under this section, if any, is not covered under any other provision in this *policy*.

All terms used in this section have the same meaning given to them in this *policy*, unless otherwise specifically defined in this section.

Schedule of pediatric dental benefits

This summary provides an overview of Pediatric Dental Benefits. Refer to the "Pediatric Dental Benefits" provision for detailed descriptions, including additional limitations or exclusions.

Benefits for Pediatric Dental Benefits will be paid at the *coinsurance* percentage shown on a maximum allowable fee basis after any applicable *deductible* has been met.

Class I Services:
Network provider: *Benefits* are paid at 100%.
Non-network provider: *Benefits* are paid at 70% after the *non-network provider deductible* has been met.

Class II Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Class III Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Class IV Services:
Network provider: *Benefits* are paid at 50% after the *network provider deductible* has been met.
Non-network provider: *Benefits* are paid at 50% after the *non-network provider deductible* has been met.

Dental Deductible:

Individual deductible:
$100 per *year* per *covered person* when *services* are provided by a *network provider*.

$100 per *year* per *covered person* when *services* are provided by a *non-network provider*.

Network Provider Plan Year Out-of-Pocket Maximum:
Once the *out-of-pocket maximum* is met, *network provider covered expenses* are paid at 100%.

PEDIATRIC DENTAL BENEFIT

Non-network provider services do not accumulate toward the *out-of-pocket maximum*.

Out-of-pocket maximum for a policy with one covered child:
$700

Out-of-pocket maximum for a policy with two or more covered children:
$700 per individual child: or
$1400 combined for all children

Pediatric dental benefits

We pay pediatric dental *benefits* on *covered expenses* as explained in this "Pediatric Dental Benefits" provision.

Class I Services:

1. Periodic oral evaluations - two every *year*. *Benefit* is not available when a comprehensive oral evaluation is performed.
2. Comprehensive oral evaluation – one every three *years*. *Benefit* is not available when a periodontal evaluation is performed.
3. Limited and problem focused oral evaluations - one every *year*.
4. Oral evaluation for a patient under three years of age and counseling with primary caregiver – two every *year.*
5. Detailed and extensive oral evaluation – problem focused, by report – one every *year*.
6. Re-evaluation – limited problem focused – one every *year*.
7. Periodontal evaluations - one every three years. *Benefit* allowed only for *covered persons* showing signs or symptoms of periodontal disease and for *covered persons* with risk factors such as smoking, diabetes or related health issues. No *benefit* is payable when performed with a cleaning (prophylaxis). *Benefit* is not available when a comprehensive oral evaluation is performed.
8. Cleaning (prophylaxis), including all scaling and polishing procedures – two every *year*. *Benefit* is not available if periodontal maintenance has been previously provided.
9. Intra-oral complete series X-rays (14 films, including bitewings) or panoramic X-ray – one every five *years*. If the total cost of periapical and bitewing X-rays exceeds the cost of a complete series of X-rays, the plan will consider these as a complete series.
10. Bitewing X-rays – one set every *year.*
11. Posterior – anterior or lateral skull and facial bone survey film – one every *year.*
12. Other X-rays including intra-oral periapical & occlusal and extra-oral X-rays – only to diagnose specific treatment.
13. Topical fluoride treatment provided to *covered persons* age 14 and younger. *Service* is payable two times every *year.*
14. Sealants – application provided to *covered persons* age 14 and younger to the occlusal surface of permanent molars that are free of decay and restorations. *Service* is payable once per tooth per lifetime.
15. Space maintainers for retaining space when a primary tooth is prematurely lost. *Services* are payable only for *covered persons* age 14 and younger for the installation of the initial appliance. Separate adjustment expenses will not be covered.
16. Recementation of space maintainer- limited to two per *year*.
17. Removal of fixed space maintainer. Limited to once per lifetime.

Class II Services:

PEDIATRIC DENTAL BENEFIT

1. Restorative *services* as follows:
    a. Amalgam restorations (fillings) – limited to one per tooth every two *years*. Multiple restorations on one surface are considered one restoration.
    b. Composite restorations (fillings) limited to one per tooth every two *years*. Composite restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
    c. Gold foil restorations (fillings) limited to one per tooth every two *years*. Gold foil restorations on molar and bicuspid teeth are considered an alternate *service* and will be payable as a comparable amalgam filling. The *covered person* will be responsible for the remaining *expense incurred*. Multiple restorations on one surface are considered one restoration.
    d. Pin retention – per tooth in addition to restoration that is not in conjunction with core build-up.
    e. Non-cast pre-fabricated stainless steel and esthetic stainless steel and resin crowns on primary teeth that cannot be adequately restored with amalgam or composite restorations. Esthetic stainless steel and resin crowns are considered an alternate *service* and will be payable as a comparable non-cast pre-fabricated stainless steel crown. *You* will be responsible for the remaining *expense incurred*. Limited to one per tooth every five *years*.
2. Simple oral surgical *services* as follows:
    a. Extraction - coronal remnants of a deciduous tooth limited to once per tooth per lifetime.
    b. Extraction - erupted tooth or exposed root limited to once per tooth per lifetime.
3. Complex oral surgery *services* as follows – limited to one per tooth per lifetime:
    a. Surgical extractions.
    b. Bone smoothing.
    c. Trim or remove over growth or non-vital tissue or bone.
    d. Removal of tooth or root from sinus and closing opening between mouth and sinus.
    e. Surgical access of an un-erupted tooth.
    f. Mobilization of erupted or malpositioned tooth to aid eruption; or surgical reposition of teeth.
    g. Excision or removal of malignant oral cysts or tumors.
    h. Bone, cartilage or synthetic grafts.
    i. General anesthesia or conscience sedation subject to *clinical review* and administered by a *provider* in conjunction with a covered oral surgical procedure and/or the *covered person* has a dental *service*. General anesthesia will not be covered for the following reasons: 1) pain control, unless documented allergy to local anesthetic; 2) anxiety; 3) fear of pain; 4) pain management; or 5) emotional inability to undergo surgery.
    j. Reduction of dislocation for temporomandibular joint dysfunction.
4. Miscellaneous *services* as follows:
    a. *Emergency* care – treatment for the initial *palliative* dental care of pain or an accidental *dental injury* to teeth or supporting structures. *We* will consider the *service* as a separate *benefit* only if no other *service*, except X-rays and/or problem focused oral evaluation, is provided during the same visit.
    b. Diagnostic consultation – *service* provided by a *provider* or physician not providing the treatment. Coverage is subject to *clinical review*.

Class III Services

PEDIATRIC DENTAL BENEFIT

1. Replacement of inlays, onlays, crowns or other laboratory-fabricated restorations. The existing major restoration may be replaced only if:
    a. It has been at least five *years* since the prior insertion and is not, and cannot be made serviceable;
    b. It is damaged beyond repair as a result of an *accidental injury* (non-chewing injury) while in the oral cavity; or
    c. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis necessitates the replacement of the prosthesis.

2. Initial placement of laboratory-fabricated restorations when the tooth, as a result of extensive decay or traumatic injury, cannot be restored with a direct placement of filling material. *Covered expenses* include inlays, onlays, crowns, veneers, core build-ups, and posts, implant supported crowns and abutments. *We* will not cover the *expense incurred* for pin retention when done in conjunction with core build-up. Limited to one per tooth every five *years*.

3. Periodontic *services* as follows:
    a) Periodontal scaling and root planing. Limited to a maximum of one every three *years* and four quadrants per visit. Additional quadrants available seven days following completion of initial quadrants.
    b) Periodontal maintenance (at least 30 days following periodontal therapy) limited to two per *year*. *Benefit* is not available when a cleaning (prophylaxis) is performed.
    c) Periodontal and osseous surgery, including bone replacement, tissue regeneration, and/or graft procedures, limited to one per quadrant every five *years*. If more than one surgical *service* is performed on the same day, *we* will consider only the most inclusive *service* performed as a *covered expense*.
    d) Occlusal adjustment only when performed in conjunction with periodontal surgery limited to one per quadrant every three *years.*

    Separate fees for pre and post-operative care and re-evaluation within three months are not covered.

4. Endodontic *services* as follows:
    a) Root canal therapy, including root canal treatments and root canal fillings – for permanent and primary teeth one time per tooth per lifetime. Any test, intraoperative, X-ray, exam, laboratory or any other follow-up care is considered integral to root canal therapy.
    b) Root canal retreatment, including root canal treatments and root canal fillings - for permanent and primary teeth, one time per tooth per lifetime. Any test, intraoperative, X-ray, exam, laboratory or any other follow-up care is considered integral to root canal therapy.
    c) Periradicular surgery, including apicoectomy, root amputation, tooth reimplantation, and/or surgical isolation for permanent teeth one time per tooth per lifetime.
    d) Partial pulpotomy for apexogenesis for permanent teeth, one time per tooth per lifetime.
    e) Vital pulpotomy – procedure available to permanent and primary teeth, one time per tooth per lifetime.
    f) Pulp debridment, pupal therapy (resorbable) – for permanent and primary teeth, one time per tooth per lifetime.
    g) Apexification/recalcification - procedure available to permanent and primary teeth, one per tooth per lifetime.

5. Prosthodontics *services* as follows:
   a) Repairs of bridges, complete dentures, immediate dentures, partial dentures, and crowns.
   b) Denture adjustments – when done by a *provider* other than the one providing the denture, or adjustments performed more than six months after initial installation - two every *year*.
   c) Initial placement of bridges, complete dentures, and partial dentures - one every five *year(s)*. Immediate dentures - one per lifetime. *Covered expenses* include pontics, inlays, onlays, crowns, relines, rebases, and/or adjustments one every five *year*s. *Services* include relines, rebases, and/or adjustments limited to six months after installation and are payable only for replacement of permanent and primary teeth.
   d) Replacement of bridges, complete dentures, immediate dentures, and partial denture. The existing prosthesis can be replaced only if:
      i. It has been at least five *years* since the prior insertion and is not, and cannot be made serviceable;
      ii. It is damaged beyond repair as a result of an *accidental injury* while in the oral cavity; or
      iii. Extraction of functioning teeth, excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis requires the replacement of the prosthesis.

These *services* are covered on permanent teeth.

   e) Tissue conditioning – one every three *years*.
   f) Post and core build-up in addition to partial denture retainers with or without core build-up - one every five *years.*

6. Implant *services* are subject to *clinical review*. Dental implants and related *services* including implant supported crowns, abutments, bridges, complete dentures, and/or partial dentures are covered subject to *clinical review*. Implant supported complete or partial dentures limited to one every five *years*. All other *services* limited to one every five *years*. No *benefit* will be allowed if it is determined that a standard prosthesis or restoration will satisfy the dental need.

7. Miscellaneous *services* as follows:
   a. Recementing of inlays, onlays, crowns, and bridges.
   b. The initial installation of fixed and removable appliances to inhibit thumb sucking and other harmful habits. Separate adjustment expenses will not be covered.

Class IV Services:

Orthodontic treatment, subject to *clinical review* and when as a result of congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. *Services* include treatment of, and appliance for, tooth guidance, interception, and correction as well as X-rays, exams, and follow-up care. Limited to one per lifetime.

Integral service

Additional charges related to materials or equipment used in the delivery of dental care. The following *services* are considered integral to the dental *service*. A separate fee for these *services* is not considered a *covered expense.*

1. Local anesthetics;
2. Bases;

3. Pulp caps;
4. Study models/diagnostic casts;
5. *Treatment plans*;
6. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
7. Nitrous oxide;
8. Irrigation;
9. Tissue preparation associated with impression or placement of a restoration.

Pediatric dental limitations & exclusions

In addition to the LIMITATIONS AND EXCLUSIONS section and any exclusions listed in this "Pediatric Dental Benefits" section, the following limitations and exclusions also apply to pediatric dental *benefits*:

1. Any expense arising from the completion of forms.
2. Any *service we* consider *cosmetic dentistry* unless it is required as a result of an *accidental injury* sustained while a *covered person* is covered under this *policy*. *We* consider the following procedures to be *cosmetic dentistry*:
   - Facings on crowns or pontics (the portion of a fixed bridge between the abutments) posterior to the second bicuspid;
   - Any *service* performed primarily to improve appearance; or
   - Characterizations and personalization of prosthetic devices.
3. Charges for:
   - Any type of implant and all related *services*, including crowns or the prosthetic device attached to it including the removal of implants, unless specified in this *policy*.
   - Precision or semi-precision attachments.
   - Overdentures and any endodontic treatment associated with overdentures.
   - Other customized attachments.

   a. Any *services* for 3D imaging (cone beam images).
   b. Additional charges related to materials or equipment used in the delivery of dental care.
   c. Charges for treatment rendered by family member or person who resides with the *covered person*.

4. Any *service* related to:
   - Altering vertical dimension of teeth or changing the spacing and/or shape of the teeth;
   - Restoration or maintenance of occlusion;
   - Splinting teeth, including multiple abutments, or any *service* to stabilize periodontally weakened teeth;
   - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction; or
   - Bite registration or bite analysis.
5. Orthodontic *service*s unless specified in this "Pediatric Dental Benefit" section.
6. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, study models, treatment plans, occlusal adjustments or tissue preparation associated with the impression or placement of a restoration when charged as a separate *service*. These *services* are considered an integral part of the entire dental *service.*

7. Any non-emergent dental *expenses incurred* for *services* rendered outside of the United States.
8. Temporary and interim dental *services;*
9. Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions, and dietary planning.
10. The replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis and/or appliance.
11. Caries susceptibility testing, lab tests, saliva samples, anaerobic cultures, sensitivity testing or charges for oral pathology procedures.
12. Any *services* for orthognathic surgery.
13. Any *services* for destruction of lesions by any method.
14. Any *services* for tooth transplantation.
15. Any *services* for removal of a foreign body from the oral tissue or bone.
16. Any *services* for reconstruction of surgical, traumatic or congenital defects of the facial bones.
17. Any *services* generally considered to be medical *services*.
18. Any separate fees for pre and post-operative *services.*

PEDIATRIC DENTAL BENEFIT

Pediatric dental definitions

The following definitions are in addition to other definitions found in this *policy*.

Covered service: A *service* that is:

1. Ordered by a *provider*;
2. For the *benefits* described, subject to all terms, provisions, limitations and exclusions of this *policy*; and
3. Incurred when a *covered person* is insured for that *benefit* under this *policy* on the *expense incurred date*.

Expense incurred date: The date on which the teeth are prepared for fixed bridges, crowns, inlays, onlays or veneers:

1. The final impression is made for dentures or partials;
2. The pulp chamber of a tooth is opened for root canal therapy;
3. Periodontal surgery is performed; or
4. The *service* is performed for *services* not listed above.

Out-of-pocket maximum: The maximum amount of *covered expense* a *covered person* or *policyholder* pays each *year* for *network provider services* covered under this *policy*. This amount includes *coinsurance* and *deductible* but does not include:

1. Amounts over the *reimbursement limit*;
2. Non-covered *services*;
3. Other *policy* limits: or
4. *Non-network provider services*.

There are separate *out-of-pocket maximums* depending on the number of children covered on this *policy*. Refer to the “Schedule of pediatric dental benefits” provision for the amount.

HUMANA INSURANCE COMPANY
Actuarial Memorandum

Dental Policy Form TN HUMD IND 2014

1. **Scope and Purpose** – The purpose of this actuarial memorandum is to describe the benefits and assumptions for the Individual Dental Policy Form TN HUMD IND 2014

2. **Benefits Description** – This Form provides benefits for covered Dental services.

Children (Ages 0-19) - Benefits may vary depending on whether or not a participating dentist is used and may be subject to coinsurance, a deductible, and a maximum out of pocket limit. The services covered include Diagnostic, Preventive, Oral Surgery, Restorations, Extractions, Recementations, Periodontics, Endodontics, Prosthodontics, Implants, and Medically Necessary Orthodontics. Please see the policy for more details on the specific benefits.

Adults (Ages 20+) - Benefits may be subject to coinsurance, may vary depending on whether or not a participating dentist is used, and may be subject to either a deductible or annual maximum or both. The services covered include Diagnostic, Preventive, Oral Surgery, Restorations, Extractions, and Recementations. Additionally, discounts on Periodontic Services, Endodontic Services, Prosthodontic Services, Implants, and Orthodontic Services may be provided when a participating dentist is used. Please see the policy for more details on the specific benefits.

3. **Renewability Clause** – This Form is Guaranteed Renewable for life at the premium rate effective on the renewal anniversary date.

4. **Applicability** – This filing is for the Individual Dental Policy Form TN HUMD IND 2014. The rates will apply to newly issued policies sold on the Exchange.

5. **Morbidity** – The claim costs assumed in pricing are based on proprietary company experience which has been adjusted when state specific experience is not credible.

6. **Mortality** – Mortality is not a significant factor in the pricing; however, the impact of mortality is reflected in the persistency rates.

7. **Persistency** – The persistency rates assumed in pricing are based on Company experience and are as follows:

Duration	Persistency
1	54%
2	58%
3+	64%

8. **Expenses** – The expense assumptions are based on the Company's incurred costs. These expenses cover general administrative, commissions, commission bonuses, premium taxes, and Exchange fees.

9. **Marketing Method** – This Form will be distributed through brokers, sales agents and directly to consumers through the internet, direct mail, e-mail, print advertising and other forms of communication. This Form will only be available to members through the Exchange.

10. **Underwriting** – This Form is guaranteed issue and not underwritten based on health status.

11. **Premium Classes** – Rates will vary based on rating area, effective date, the age of each insured member on a policy, and the number of members on a policy limited to adults and no more than 3 dependent children. The premium algorithm is shown in the associated Rate Manual.

12. **Issue Age Range** – There are no restrictions on issue age.

13. **Area Factors** – The premium rates for this form will vary by rating area. The area factors are displayed in the associated Rate Manual.

14. **Trend Factor** – The premium rates for this form will vary by trend factor. The trend factors are displayed in the associated Rate Manual.

15. **Average Annual Premium** – The anticipated average annual premiums per policy for this Form are $380.

16. **Premium Modalization Rules** – This Form will be primarily billed monthly. Quarterly rates will be three times monthly rates, semi-annual rates will be six times monthly rates and annual rates will be twelve times monthly rates.

Please see the associated Rate Manual for additional premium information.

17. **Claim Liability and Reserves** – The IBNR claim reserves will be set based on a claim lag basis. A check against historical claim PMPMs and paid claims for the first lag month will also be made to assure there is no major shift from historical experience. Claim reserves will use an anticipated loss ratio method until relevant experience is available to complete reserves based on a claim lag basis.

18. **Active Life Reserves** – Statutory active life reserves will be gross unearned premiums.

19. **Trend Assumption** – Annual trend is expected to be up to 10% per year.

20. **Contingency and Risk Margins** – The risk margin for this Form is sufficient to meet the minimum return on the Company's Risk-based Capital requirements.

21. **Experience** – This is a new form with no experience.

22. **Lifetime Loss Ratio** – The anticipated lifetime loss ratio exceeds 55%.

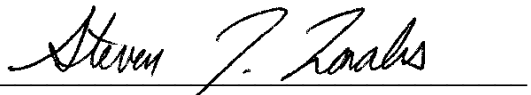
23. **History of Rate Adjustments** – This is a new form.

24. **Number of Policyholders** – This is a new form.

25. **Proposed Effective Date** – January 1st, 2014.

26. **Actuarial Certification** – I, Steven J. Laabs, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify that to the best of my knowledge and judgment:

(i) this entire rate filing is in compliance with the applicable laws of the state and with the rules of the Department of Insurance;
(ii) complies with applicable Actuarial Standards of Practice; and
(iii) that the benefits provided by this Form are reasonable in relation to the proposed premiums, which are neither excessive, inadequate, nor unfairly discriminatory.



May 28, 2013

Steven J. Laabs, FSA, MAAA
Managing Actuary
Humana Inc

Date